Date: 18 June 2019  
Subject: Improving Specialist Care: Neuro-Rehabilitation Full Business Case  
Report of: Steve Dixon, Chief Finance Officer and Deputy Chief Accountable Officer, Salford Clinical Commissioning Group/Commissioning Lead for Neuro-Rehabilitation

PURPOSE OF REPORT:

This report is categorised as relating to “Level A” business as set out in the JCB Terms of Reference – Section 10.

The purpose of this report is to present the Full Business Case for the acute neuro rehabilitation services in Greater Manchester. In addition, this report provides additional assurance that JCB requested on four main areas:

- Equality impact assessments
- Travel impact assessment
- Community Neuro-Rehabilitation services in each locality
- Financial analysis

KEY ISSUES TO BE DISCUSSED:

The Board is invited to consider the content of the Full Business Case, as well as considering the additional assurance provided on the four specific points set out above.

In doing so, the Board is asked to note that legal advice has been taken on the process undertaken to date and that advice has confirmed that the process followed has been thorough and that there are no material risks from the process to date or in the recommendations.

Members’ attention is drawn to the fact that some elements of the proposal set out in the Full Business Case relate to elements of the specialised commissioning portfolio, (described as “Tier One” services), which have been delegated by the Board of NHS England to the Chief Officer of the GM Health and Social Care Partnership. Therefore, this proposal requires the support of both the Joint Commissioning Board and the Chief Officer of the Health and Social Care Partnership. The Chief Officer has been furnished with the same information for consideration as the JCB and will be invited to reach his decision at the same time as the JCB.

RECOMMENDATIONS:

The Greater Manchester Joint Commissioning Board is asked to:
• Note contents of report, in particular the additional assurance that JCB requested in relation to equality impact assessments, travel impact assessment, community neuro rehabilitation services and the financial impact

• Agree the full business case for acute neuro rehabilitation services, specifically approving the elements relating to CCG commissioned services and expenditure

CONTACT OFFICERS:

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SYSTEM ENGAGEMENT

Please complete the information below to outline the discussion with sectoral governance groups prior to submitting to the GM Joint Commissioning Board. If it is not appropriate / deemed necessary for a discussion with a particular group please state why.

PRIMARY CARE ADVISORY GROUP (PCAG)
Has the paper been discussed by PCAG? No

PROVIDER FEDERATION BOARD (PFB)
Has the paper been discussed by PFB? No

WIDER LEADERSHIP TEAM (WLT)
Has the paper been discussed by WLT? No

STRATEGIC PARTNERSHIP EXECUTIVE BOARD (PEB)
Has the paper been discussed by PEB? No

GM CCG DIRECTORS OF COMMISSIONING (DOCS)
Has the paper been discussed by DoCs? Yes
Date of meeting: 14th May and 11th June 2019
Key points to be fed into JCB:
  • Comments included in Appendix 1

GM CCG CHIEF FINANCE OFFERS (CFOS)
Has the paper been discussed by CFOs? Yes
Date of meeting: 14th May and 11th June 2019
Key points to be fed into JCB:
  • Comments included in Appendix 1

GM LA HEADS OF COMMISSIONING (HOCS)
Has the paper been discussed by HoCs? No
If no please outline the reason: N/A

Note: There was more comprehensive system engagement on the Case for Change and Model of Care prior to these being approved by JCB in October 2018. System engagement on this JCB report and Full Business case has been limited to the commissioning groups (DoCs, CFOs, GMSCOG) and key discussion captured within appendix 1
1.0 INTRODUCTION AND BACKGROUND

1.1. Improving specialist Care Programme (ISCP) (formally Theme 3) has been set up to deliver the strategy outlined in the Greater Manchester (GM) Health and Social Care Partnership strategic plan ‘Taking Charge’; specifically, significant improvements to the quality, safety and efficiency of the care patients receive when they need to be treated in hospital.

1.2. The transformation priorities for the programme were developed with clinicians, providers and commissioners over several months culminating in a proposal from the Theme 3 Steering Group which was endorsed by CCGs, the Provider Federation Board, and the Strategic Partnership Board Executive on the 19th September 2016. Acute Neuro-Rehabilitation services were identified as one of these Transformation priorities.

1.3. The Acute Neuro Rehabilitation pathway underwent a standardised design and approval process which consisted of:

- **Case for Change** – Approved by the ISCP Board and Executive in August 2017.

- **Model of Care** – The Model of Care was supported by the Clinical Reference Group in January 2018 and the ISCP Board and Executive in April 2018.

1.4. The Greater Manchester Joint Commissioning Board (JCB) approved the model of care on 16th October 2018.

1.5. The model of care was presented to the Greater Manchester Joint Overview and Scrutiny Committee (JOSC) to determine if any further conversations with patients and the public were required. In November 2018, JOSC concluded that formal public consultation was not required as involvement and engagement activities proportionate to the number of patients affected by the proposed change had been undertaken during the design process.

1.6. The design process was submitted to NHS England (NHSE) to ensure that NHSE’s 5 stage process had been adhered to in relation to proposed service change. NHSE confirmed the design process met their requirements and the workstream could move into the next phase.

1.7. In preparation of the production of the full Business Case, on 19th March 2019, JCB approved the:

- Criteria and Decision-Making Process in Selecting the single provider and approved the single provider as the GM Neurosciences Centre (SRFT).

- Site and bed-base configuration- maintaining acute neuro rehabilitation beds at the existing four sites in GM.

- Framework and level of detail required in the Full Business Case, which is presented today.
1.8. JCB specifically asked for the full business case and supplementary information to focus and give assurance on:

- The full financial impact of implementing the model of care
- Equality Impact Assessment
- Travel Impact assessment
- Community Neuro-rehab services - whilst the business case relates to acute (hospital) neuro rehabilitation, assurance is required that high quality community services are in place

These areas are covered in sections 2 - 4 of this report.

2.0 FULL BUSINESS CASE

2.1. The Full Business Case is included as a separate report. This has been developed along the green book 5 case model.

2.2. The estimated total spend for commissioners for the current acute inpatient neuro rehabilitation pathway in Greater Manchester is £25m and the new model is expected to cost around £24.1m. The total cash releasing financial saving is around £1.1m, being around £0.9m on inpatient spend and a further £0.2m reduction in outpatients.

2.3. In addition, the new model is expected to reduce the continued year on year increase in individual packages of care placed outside of GM. The number and cost of placements made with Independent Sector providers has increased by over 30% in the past couple of years. The new model of care, compared with the “do nothing” scenario would save an additional £5.7m if the level of growth can be contained.

2.4. Comparing the new model of care against the “do nothing” scenario is a methodology consistent with the modelling being undertaken on the other ISC programme. The total savings of the new model compared with the “do nothing” scenario equate to around £6.8m in total (cash releasing savings of £1.1m and containing future growth £5.7m).

2.5. The impact of provider costs has been completed and included in the full business case. The NHS provider financial position has improved by circa £0.5m by implementing the new model of care.

2.6. Assessment against the full list of the GM Finance and Estates Reference Group (FERG) principles is included in the business case and were discussed at the GM Provider Directors of Finance (DoF) meeting (6\textsuperscript{th} June) and a joint DoF and CFO meeting on 11\textsuperscript{th} June 2019. These groups concluded that the FERG principles had been met in so far as the collective GM providers’ financial position has not worsened (and in fact slightly improved) as a result of introducing this model of care and that stranded costs had been minimised. Further work is required during implementation to fully understand the financial impact on each
individual provider organisation and how funding is moved around the system as a result of implementing a single provider model. This is important to consider this detail not just for the neuro rehabilitation model but for the wider Improving Specialist Care (ISC) programme.

2.7. In relation to capital costs, the new model has been estimated to cost between £2m to £3m. Whilst the existing sites across GM are being used for the neuro rehabilitation pathway, one ward on the Salford Royal site would need to be re-purposed to accommodate additional specialist patients (Prolonged Disorder of Consciousness (PDOC) and Tracheostomy patients). It is acknowledged that there is no capital available at a national or GM level. Therefore this is a local issue to be resolved in the Salford locality. Salford Royal and Salford CCG have agreed to find a local solution to this.

2.8. The business case has been taken through a number of meetings across Greater Manchester. A summary of the discussions and amendments made to the business case as a result of this engagement process is included in Appendix 1.

3.0 COMMUNITY NEURO-REHAB SERVICES

3.1. Community neuro-rehabilitation services are vital to the sustainability of the whole of the neuro-rehabilitation pathway including the new acute model of care. Both are integral elements to working towards managing more people out of the hospital setting and supporting self-management.

3.2. Significant work has already been completed in developing a standardised service specification for community neuro rehabilitation services. This specification has been approved. Commissioners in all 10 localities have started the process of commissioning local services to deliver against the standards within the specification. There are currently four localities in Greater Manchester that have commissioned services to the specification (North Manchester, Stockport, Salford and Heywood, Middleton and Rochdale), two of which (North Manchester and Stockport) are now delivering to the specification and the other two are in implementation.

3.3. Each locality has been asked to provide an assurance statement on progress being made in each locality on implementing the community neuro rehabilitation standards. The status of community neuro rehabilitation services for each locality is outlined in Appendix 2.

3.4. In order for the full benefits of the acute neuro rehabilitation pathway to be realised, the implementation of a community service in all 10 GM localities meeting the community service specification and standards is required by April 2020.

3.5. All 10 localities are committed to implement the community pathway. However some risks to implementing the community standards have been raised by some localities, in particular timescales to recruit and potential lack of available workforce. This will be monitored throughout the implementation phase.
4.0 EQUALITY IMPACT ASSESSMENTS

4.1. Equality Impact Assessments (EIA) were undertaken for all ISCP workstreams by Equality Diversity Development Services Ltd on behalf of the GMHSCP. This section provides a summary of the issues and key considerations with regards to meeting the duties relating to Public Sector Equality Duty (Section 149) outlined within the 2010 Equality Act.

4.2. The Equality Impact Assessment (EIA) considers the new neuro-rehab model of care and the impact on patients and carers with protected characteristics accessing services. The primary source of ‘consultation feedback’ was from ‘patient groups’. The EIA noted that an outcome of the proposed change will be that care would be delivered closer to home. Equality impacts to patients accessing the service would also be minimal.

4.3. The report made several recommendations related to equality implications:

- The units continue to deliver high quality service and continue to place the patients and key visitors at the heart of the patient’s recovery.
- Units to review how they support key visitors to the patients by offering advice with travel and Healthcare Travel Costs Scheme (HCTCS) and ensuring those pathways for support are known to patients.
- The units start to record how key visitors travel to see patients, noting in particular public transport use and any difficulties with public transport (Time/cost/delays/cancellation of key routes). After 12 months review of the data, if the data shows that some visitors are having great difficulty, especially linked to disability, then the unit and commissioners to consider how more immediate support can be given (e.g. taxi service).
- The unit to review its equality policy and how it supports different protected characteristics and their needs, especially transgender patients. Link with key community groups for their input and update policy and practice where necessary.
- Link, as part of evidence gathering, with the Mayor of Manchester’s campaign to bring all bus companies back in to one service provision.

4.4. These recommendations and any further equality needs and requirements of patients and carers will be monitored during implementation and built into the benefits framework for ongoing reporting. The full equality report can be found in Appendix 3.

5.0 TRAVEL IMPACT ASSESSMENT

5.1. The travel impact assessment has been completed and is included in the full equality impact assessment (Appendix 3). Transport for Greater Manchester (TfGM) validated the methodology and confirmed that the analysis was robust. The initial analysis for Neuro-Rehab was presented to the JOSC on 14 November 2018.
5.2. The key points of the travel analysis were:

- As the new Model of Care does not propose current inpatients within the NHS in GM will move to a different site – or that those currently receiving inpatient care in the independent sector would move to a different site - it can be concluded that the journey times would relate to new patients.

- It can also be concluded that there will be reductions in journey times as a result of implementing a new Model of Care which will provide the majority of hospital inpatient care within Greater Manchester with only very occasional exceptions. The new Model of Care will result in fewer patients placed outside of Greater Manchester.

5.3. To supplement the McKinsey travel analysis GM Healthwatch is going to undertake some “lived experience” journeys. These public transport tests will be supported by TfGM.

6.0 ROLE OF THE LEAD COMMISSIONER

6.1. The lead commissioning role will differ during implementation to post-implementation. During implementation the role will focus on oversight of the implementation via the implementation steering group. They will also support development of the readiness assessment as part of the benefits framework implementation to ensure the service is ready to ‘go-live’.

6.2. Post implementation the role will be contracting focussed as outlined in the commercial case within the business case. The role of the lead commissioner will be considered as part of the review and recommendations within the GM Commissioning review paper and linked to the role of the GM Joint Commissioning Team.

7.0 RECOMMENDATION

7.1. The Greater Manchester Joint Commissioning Board is asked to:

- Note contents of report, in particular the additional assurance that JCB requested in relation to equality impact assessments, travel impact assessment, community neuro rehabilitation services and the financial impact

- Agree the full business case for acute neuro rehabilitation services, specifically approving the elements relating to CCG commissioned services and expenditure
### APPENDIX 1: FULL BUSINESS CASE DEVELOPMENT- ENGAGEMENT ACROSS GREATER MANCHESTER

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Main Discussion Items</th>
<th>Comments and/or Amendments to Business Case</th>
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<tbody>
<tr>
<td>14/5/2019: Joint Session: GM CCG Directors of Commissioning (DoCs) and GM CCG Chief Finance Officers (CFOs)</td>
<td>Wanted to see full equality impact and travel impact analysis- these have been shared. Discussion on community services- each DoC agreed to provide a form of words from each locality on status. Each locality confirm commitment to implementing the community service specification but queried timeframe Recognise some cash releasing savings and good to see the cost containment savings compared with “do nothing”. Wanted to stress the non-financial benefits- ie the quality benefits within the model of care</td>
<td>Additional information shared with DoCs. Quality benefits highlighted in business case. Updated community information in business case</td>
</tr>
<tr>
<td>29/5/2019 GM Specialist Commissioning Oversight Group (GMSCOG)</td>
<td>How confident that the bed modelling is correct? Any sensitivity analysis on length of stay reductions? How do we get assurance that patient flow between Salford Royal site and other sites is working? This will be picked up through implementation- and overseen and monitored by neuro rehab group (commissioners and provider)</td>
<td>Updated implementation governance section in business case</td>
</tr>
<tr>
<td>5/6/2019: GM Manchester Finance and Estates Reference Group (FERG) and GM Provider Directors of Finance</td>
<td>Discussion on the economic case and whether the FERG principles have been met. Focus on whether the recurrent revenue position under the new model is no worse than the current financial position. Consideration of stranded costs, use of existing estates and capital. Concluded that the FERG principles had been met but further work required during implementation to fully understand the financial impact on each provider organisation and how funding is moved around the system. Follow up discussion between CFOs and Dofs in June which will be taken forward in the wider ISC work programme.</td>
<td>Updated provider finance section and FERG principles. Added item on implementation plan</td>
</tr>
<tr>
<td>6/6/209: Improved Specialised Care Sub Group</td>
<td>The discussion focussed on the JCB report to ensure it provides assurance on the 4 areas raised during model of care approvals process (equality impact assessment, travel assessment, community and finance). Conclusion that the Full Business Case and JCB report includes all of the relevant information for JCB</td>
<td>All 3 groups recommend approval of the Full Business Case to JCB</td>
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<tr>
<td>11/6/2019: GM CCG DoCs</td>
<td>Review of final business case and JCB paper</td>
<td></td>
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<td>11/6/2019: GM CCG CFOs</td>
<td>Review of final business case and JCB paper</td>
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APPENDIX 2: COMMUNITY NEURO REHABILITATION SERVICES

<table>
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<th>Locality</th>
<th>Status at June 2019</th>
<th>Anticipated Completion of Service Specification Implementation</th>
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<tr>
<td>Bolton</td>
<td>Bolton locality is working collaboratively to meet the key elements of the GM service specification which includes ensuring that the current waiting times are significantly reduced to the specification standards. Non recurrent funding has been identified to support the service redesign required. The locality is working to the revised service being operational from October 2019 but workforce to manage the current waiting list will be a challenge.</td>
<td>Oct-19</td>
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<tr>
<td>Bury</td>
<td>The CCG agreed a business case for additional investment in 2018-19 to develop an integrated stroke and neuro-rehabilitation service. The Community Stroke service exists and is well regarded and its integration with a community neuro-rehabilitation service will provide further resilience. It will be implemented in phases and mobilisation of Phase 1 will ensure compliance with the majority of the GM specification.</td>
<td>Aug-19</td>
</tr>
<tr>
<td>Heywood, Middleton and Rochdale (HMR)</td>
<td>HMR CCG has invested additional funding to ensure that community neuro rehab provision meets the GM specification and staffing structure. HMR CCG now has a Community neuro rehab (CNR) steering group that meets monthly to ensure that the CNR team continues to meet the GM specification and that wait times for the service are managed appropriately. The steering group has membership from HMR CCG planned care lead, BI, CNR team lead, clinical lead and GM Neuro rehab network. The steering group recently held a productive workshop on the pathway. The workshop was successful in identifying blockages in the service pathway and an action plan will be formed to take this forward.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>North Manchester: Completed: Business as Usual</td>
<td>Central and South Manchester: There is a designated commissioning lead in place for community neuro rehab and stroke services. A strategic outline case (SOC) will be considered by Executive committee in June 2019, setting out options and delivery costs in the context of the GM specification requirements. They are reviewing the north service and may need to prioritise resources to ensure an operational city wide community neuro rehab service. The SOC will be considered alongside other CCG priorities; the intention would be to progress to full business case in October/November 2019. The intention is for the service to be operational from April 2020 although this is dependent upon exploration and mitigation of a number of risks, including for example, recruitment and training of workforce, relevant to population need. The intended GM acute services implementation date will need to align with provider feasibility considerations in terms of community delivery, which may not be entirely ‘linear’ nor deliverable by April 2020, and which remain to be explored.</td>
<td>Completed</td>
</tr>
<tr>
<td>Locality</td>
<td>Status at June 2019</td>
<td>Anticipated Completion of Service Specification Implementation</td>
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<td>Oldham</td>
<td>The CCG has made provision to develop existing service and will consider on receipt of a full business case. The CCG has a meeting scheduled between commissioning and service leads to further discuss the investment options and agree a final business case for submission to NHS Oldham CCG for review. To bring the service fully in line with the service specification, the CCG estimates £700K is required recurrently. There is concern that recruitment to a fully staffed service in a reasonable timescale is not realistic and a more phased, fluid solution is required that carefully monitors improvements against outcomes.</td>
<td>Not known</td>
</tr>
<tr>
<td>Salford</td>
<td>Business Case Approved with additional funding into existing teams to increase staffing and meet the GM specification; The CCG case was approved in June 2018 and the new team is almost established and operational. The CCG expects a fully established service by the end of June 2019. The service will be compliant with the GM models for stroke and community neuro rehabilitation.</td>
<td>Jul-19</td>
</tr>
<tr>
<td>Stockport</td>
<td>Completed; at Business as Usual</td>
<td>Completed</td>
</tr>
<tr>
<td>Tameside &amp; Glossop</td>
<td>The Tameside and Glossop model of care is closely aligned to the GM specification and meets all required standards. The existing service can cope with the current and projected level of demand. The Strategic Commissioners and Integrated Care Foundation Trust work closely together to monitor safety, activity levels and the effective flow of patients.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Trafford</td>
<td>The CCG has confirmed MFT as the stability partner for community services. The CCG and MFT are working through a process of due diligence which they are due to complete by October 2019. No formal decisions have been made in respect of the new community neuro rehabilitation service as yet. The CCG is starting to undertake profiling for the business case workforce modelling and it is the intention to develop the business case over the next couple of months. The CCG is assessing what can put in place, working to the timescales that the GM specification requires. A gap analysis against the specification has also been undertaken and referring to the compliance indicators from the ODN. The CCG wants to be in a position to operate the service from October.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Wigan</td>
<td>The business case was presented to the Healthy Wigan Partnership Board for consideration and approval. The recommendation to agree the business case and progress to immediate implementation was approved. The service will be a joint community neuro rehabilitation / stroke service however it is the intention to adopt a phased approach, starting with community neuro rehabilitation in the first instance to decrease waiting times.</td>
<td>Jan-20</td>
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APPENDIX 3 – EQUALITY ANALYSIS REPORT

Equality%20analysis%20report%20on
IMPROVING SPECIALIST CARE PROGRAMME

ACUTE NEURO-REHABILITATION SERVICES:

FULL BUSINESS CASE

JUNE 2019

CONTACT OFFICERS:

Steve Dixon
Chief Finance Officer and Deputy Chief Accountable Officer
Salford CCG
Commissioning Lead for Neuro-Rehabilitation
### Document information

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<tr>
<td>Owner:</td>
<td>Steve Dixon (Lead Commissioner)</td>
</tr>
<tr>
<td>Author:</td>
<td>NHS Transformation Unit</td>
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<td>1st draft</td>
<td>29th March 2019</td>
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<tr>
<td>2.0</td>
<td>Matt Wright</td>
<td>Amended with comments</td>
<td>17th April 2019</td>
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<td>3.0</td>
<td>Matt Wright</td>
<td>Amended with comments</td>
<td>29th April 2019</td>
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<td>Matt Wright</td>
<td>Amended with Financial information added and NHSE comments</td>
<td>2nd May 2019</td>
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<tr>
<td>5.0</td>
<td>Matt Wright</td>
<td>Additional financial information, formatting and contents page updated</td>
<td>7th May 2019</td>
</tr>
<tr>
<td>6.0</td>
<td>Steve Dixon</td>
<td>Proof read, minor amendments, clarification on governance and amended Economic case narrative</td>
<td>8th May 2019</td>
</tr>
<tr>
<td>7.0</td>
<td>Matt Wright</td>
<td>Updated with amendments</td>
<td>8th May 2019</td>
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<td>Steve Dixon</td>
<td>Updated the latest community neuro rehabilitation information and completion of the provider costs section.</td>
<td>6th June 2019</td>
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Appendix 1 Neuro-Rehabilitation Model of Care
Appendix 2 Community Neuro-Rehabilitation Service Development Status
EXECUTIVE SUMMARY

The improving specialist care programme (ISCP) has enabled the transformation of acute neuro-rehabilitation to move forward. For over a decade the Neuro-Rehabilitation service has experienced significant difficulties with patient flow and consistency of provision across Greater Manchester.

Following a standardised design and approval process the clinical case for change and co-produced model of care have been developed and were approved by the ISCP Board and Executive in April 2018. The new model of care alongside the GM Neurosciences Centre at Salford Royal NHS Foundation Trust (SRFT) as the single provider will help reduce variation of service delivery across Greater Manchester and reduce the requirement for independent sector beds by providing more care within the NHS service.

The estimated recurrent cost impact of the new model to commissioners excluding any non-recurrent costs such as capital or transitional support would be around £1.1m cash releasing savings for commissioners and a further £5.3m savings relating to avoiding future growth. The NHS provider financial position improves by around £0.5m as a result of implementing the new model of care.

Benefits of the new model will be tracked using a robust benefits framework which not only measures ‘readiness to go-live’ but also onward tracking of aligned clinical standards.

A formal governance structure will be developed to oversee implementation. Once implemented, this will be further developed to ensure consistency of service across the whole neuro-rehab pathway including community services.

INTRODUCTION

Neuro-Rehabilitation is a complex medical process which aims to aid patients recover from an illness, long-term condition or injury to the nervous system and to minimise and/or compensate for any functional alterations resulting from it.

Of the admissions in Greater Manchester in our hospital settings where Neuro-Rehabilitation is provided, typically around 50-60% have an acquired brain injury, 10-15% have damage to their spinal cord and peripheral nervous system and 10-15% might have conditions such as Multiple Sclerosis.

Neuro-Rehabilitation offers patients a series of therapies from the psychological to occupational, teaching or re-training patients on mobility skills, communication processes, and other aspects of that person’s daily routine. It can also include a focus on nutrition, psychological and creative parts of a person’s recovery.

Neuro-Rehabilitation services within Greater Manchester provide rehabilitation for patients with neurological illness, injury or long-term condition in the hyper-acute, acute, post-acute, slow stream or community setting. Hyper Acute and Acute Neuro-Rehabilitation services are currently provided as part of the Manchester Centre for Clinical Neurosciences; they are co-located with the Major Trauma Centre at Salford Royal NHS Foundation Trust (SRFT) and are commissioned by NHS England Specialist Commissioners. Post-Acute Neuro-Rehabilitation Services are provided by three NHS Trusts and commissioned by Clinical Commissioning Groups (CCGs).
Each of the NHS inpatient services are managed by a different Trust and commissioned separately. Outcomes such as length of stay and time from referral to admission vary between the services; as do practices such as admission and discharge planning.

Due to national recommendations developed since 2013 for managing/assessing neurological patients with Prolonged Disorders of Consciousness (PDoC) and/or tracheostomy in minimum cohorts to ensure appropriate expert care, such patients who require post-acute inpatient rehabilitation are not managed in the three post-acute units. Because of the complex needs of these patients, clinicians managing them must have appropriate specialist skills and the infrastructure to support safe patient care. Consequently, in GM patients, with PDoC and/or tracheostomy who require post-acute rehabilitation are directed towards independent sector placements that are often outside of Greater Manchester and remain in acute Neuro-Rehabilitation beds whilst the process to agree and find a placement is completed. In addition, these low volume/complex placements are monitored by commissioning organisations who may not have access to the relevant expertise and rely solely on the assessments and advice supplied by the providers. For these reasons patients often remain in independent sector beds for many months longer than clinically required.

Patient flow is inadequate, inequitable and disjointed across the system. There is a lack of appropriate and timely access to beds and to community services with uncoordinated access to care at all levels.

There is poor access to post-acute Neuro-Rehabilitation. There is no directly commissioned NHS service for slow-stream rehabilitation or medically stable Neuro-Rehabilitation patients who display severe challenging behaviour (SCB) and require post-acute services. Instead individual funding requests are submitted and considered by CCGs and ad hoc placements arranged both within and outside of GM, mainly within the independent sector. GM CCGs spend approximately £6.2 million per year (2018/19) on slow-stream rehabilitation placements, contracting with multiple different providers. The number of placements and the costs of Independent Sector placements have increased considerably over the past couple of years. Frequency of reviews of patients within these placements varies between CCGs and anecdotally, commissioners have expressed concern about patients spending too long in independent sector placements and whether they have the expertise in Neuro-Rehabilitation to review placements.

This business case details the case for change for the existing service, how the new model of care will improve delivery of care, the financial implications and benefits for the new service and how the service transformation will be managed.

1. STRATEGIC CASE

1.1 INTRODUCTION

The strategic case describes the current model of care and the case for change for service transformation. It describes the model of care and how it has been co-produced with clinicians and patients. It outlines the proposed benefits to implementing the new model of care and the risks and
constraints to implementation. It also highlights the robust governance process that the new model of care has been taken through before business case development.

1.2 BACKGROUND

For over a decade the Neuro-Rehabilitation service has experienced significant difficulties with patient flow and consistency of provision across Greater Manchester. Service change is required in order to achieve optimal patient outcomes.

In 2013 commissioners invested in an additional 20 beds to improve flow (10 additional level 1 beds and 10 additional level 2 beds) to bring the Greater Manchester inpatient NHS service to 117 beds. The intention, at that time, was for the provision of community Neuro-Rehabilitation services to be considered as a second phase after the introduction of the additional beds. In 2016 a Greater Manchester service specification for community Neuro-Rehabilitation was developed in collaboration with clinicians and commissioners; however to date only two of the ten localities in GM have implemented a service as per the service specification. Greater Manchester has the highest number of Neuro-Rehabilitation beds per head of population than anywhere else in the UK.

In 2015 an Operational Delivery Network (ODN) was established to identify and address issues and improve patient flow. Since 2015 the ODN has been advocating whole-system service transformation due to the issues described herein and on the basis that improved efficiency and improved service provision will reduce the need for the current number of beds.

Hyper Acute and Acute Neuro-Rehabilitation Services are co-located with the Neurosciences Centre and Major Trauma Centre and provided by Salford Royal NHS Foundation Trust (SRFT). This specialised service is comprised of 30 beds (20 hyper-acute and 10 acute) and is commissioned by NHSE to a value of £5.8 million p.a. The hyper-acute beds attract a bed day tariff, whilst the 10 acute beds are funded through a block contract.

Post-acute Neuro-Rehabilitation Services are provided by three NHS Trusts and commissioned by several clinical commissioning groups as described in the table below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Name</th>
<th>Number of Beds</th>
<th>GM CCG Annual Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Each of the NHS inpatient services are managed by a different trust and commissioned separately, with no consistency of tariffs. Outcomes such as length of stay, time from referral to admission etc. vary between the services; as do practises such as admission and discharge planning.

Due to national recommendations for managing/assessing neurological patients with prolonged disorder of consciousness and/or tracheostomy in minimum cohorts, patients who require post-acute rehabilitation inpatient services cannot be managed in the three post-acute units. Instead, the patients are usually directed towards independent sector placements and remain in acute Neuro-Rehabilitation beds whilst the process to agree and find a placement is completed. In addition, these low volume/complex placements are monitored by commissioning organisations who may not have access to the relevant expertise and rely solely on the assessments and advice supplied by the providers. Patients can remain in independent sector beds for many months longer than clinically required.

There are no routinely commissioned NHS slow-stream Neuro-Rehabilitation services in Greater Manchester, or any routinely commissioned post-acute services for people with severe challenging behaviour. Instead, individual funding requests are made and placements arranged on an ad hoc basis with multiple different providers, both within and out-with Greater Manchester. The GM CCG spend on slow-stream Neuro-Rehabilitation placements has grown in the last 2 years from c. £4.5 million per annum to c. £6.15 million per annum in 2018-19. The spend on post-acute services for people with severe challenging behaviour is unknown, however all people are placed outside of Greater Manchester due to the lack of specialist facilities within the region.

Table 1 Post-acute Neuro-Rehabilitation Services

<table>
<thead>
<tr>
<th>Trust</th>
<th>Unit</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manchester Foundation Trust</td>
<td>Trafford Intermediate Neuro-Rehabilitation Unit (INRU)</td>
<td>30</td>
</tr>
<tr>
<td>Pennine Acute Trust</td>
<td>Floyd Unit</td>
<td>18</td>
</tr>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>Devonshire Centre</td>
<td>19</td>
</tr>
<tr>
<td>Manchester Foundation Trust</td>
<td>Taylor Unit at Trafford General</td>
<td>20 (currently only 10 open)</td>
</tr>
</tbody>
</table>

£13.0 million
1.3 CASE FOR CHANGE

The case for change and model of care were developed through the Improving Specialist Care Programme (Theme 3) Governance process in April 2018 and approved by GM Joint Commissioning Board (JCB) in October 2018. The model of care is included as appendix 1.

The key drivers for change in the inpatient Neuro-Rehabilitation are:

- **Patient flow is inadequate, inequitable and disjointed across the system.** There is a lack of appropriate and timely access to beds and to community services with uncoordinated access to care at all levels. Admission and discharge criteria for all levels of neurological rehabilitation require strengthening to minimise blockages and to overcome barriers to appropriate care, to ensure patients are in the right setting for their rehabilitation need. Blockages in Neuro-Rehabilitation beds alone amount to c. 9000 lost bed days and c. £3 million per annum. In addition, people spend c. 8000 bed days in other GM NHS beds (i.e. in District General Hospital (DGHs)) per annum, waiting for a GM Neuro-Rehabilitation bed. Appropriately resourced services need to be commissioned to meet demand and avoid the current waste in the system. Furthermore, delayed outflow from the Neurosciences Centre leads to difficulties in accepting urgent and emergency transfers into Neurosurgery in a timely manner, introducing a significant clinical risk.

- **Inadequate care and flow for tracheostomy (due to neurological deficits) and PDoC patients** because the current post-acute Neuro-Rehabilitation services are not able to meet national standards for both tracheostomy and PDoC patients. Those patients requiring ongoing rehabilitation after medical stabilisation can wait for prolonged periods of time in acute beds waiting for a commissioning decision and independent sector placement.

- **Poor access to post-acute Neuro-Rehabilitation.** There is no directly commissioned service for slow-stream rehabilitation or medically stable Neuro-Rehabilitation patients who display SCB and require post-acute services. Instead individual funding requests are submitted and considered by CCGs and ad hoc placements arranged both within and outside of GM, mainly within the independent sector. GM CCGs spend approximately £4.5 million per year on slow-stream rehabilitation placements, contracting with multiple different providers. Frequency of reviews of patients within these placements varies between CCGs. Anecdotally, commissioners have expressed concern about patients spending too long in independent sector placements and whether they have the expertise in Neuro-Rehabilitation to review placements.

- **Post Acute services vary,** including waiting times to access the services, practices within services including admission and discharge planning, staffing levels, outcomes, key performance indicators e.g. average length of stay varies between post-acute services (88 days – 156 days).

- **Community services vary** and this creates unacceptable inequalities in access to care. The impact of inadequate community Neuro-Rehabilitation services includes longer lengths of stay for some inpatients, people are admitted to inpatient services inappropriately, suboptimal patient outcomes and, in some cases, failure to reach individual potential and poor patient experience.
• **Tariff varies between inpatient services both within GM and with neighbouring services.** Within GM, the post-acute Neuro-Rehabilitation service bed day rates vary from £385 to £426 per day. **Level 1** are high cost / low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements. These services are sub-divided into: **Level 1a** - for patients with high physical dependency and **Level 1b** - mixed dependency. The tariff for the level 1a service in GM is £487, significantly lower than the equivalent service in Cheshire & Merseyside which has a bed day rate of £550. The level 1b service in GM is funded to a higher level (£587) than the equivalent level 1b service in Cheshire & Merseyside (£550). The current tariff in GM does not enable the service to operate with sufficient staff and is one of the primary root causes of the service difficulties.

• **Significant variation in investment in Community Neuro-Rehabilitation services between different regions of GM.** The low levels or lack of investment in community Neuro-Rehabilitation services does not allow the service to operate with sufficient staff and is one of the primary root causes of the service difficulties described earlier.

• **Demand for Neuro-Rehabilitation services has increased and is expected to increase further in the future. The existing service cannot meet current demand.** With advances in acute medical/surgical care, increasing numbers of patients are surviving events that they would have unfortunately died from in the past. Patients are also surviving with more complex rehabilitation and care needs. In addition, the population continues to grow and people are generally living longer.

• **Staffing levels fall significantly short of national and/or local recommendations.** This is primarily because of insufficient investment in both inpatient and community services and results in variation between services, longer lengths of stay, sub-standard patient outcomes and experience and ultimately greater reliance and dependency of patients on other services e.g. GPs, health & social services packages of care, avoidable hospital admissions etc.

### 1.4 CURRENT MODEL OF CARE

Neuro-Rehabilitation services provide rehabilitation for patients with neurological illness, injury or long-term condition in the hyper-acute, acute, post-acute, slow stream or community setting.

**Hyper Acute and Acute Neuro-Rehabilitation Services** are currently provided as part of the GM Neurosciences Centre and co-located Major Trauma Centre at SRFT.

**Post-Acute Neuro-Rehabilitation Services** are provided by three NHS Trusts and commissioned by Clinical Commissioning Groups (CCGs).

Each of the NHS inpatient services are managed by a different Trust and commissioned separately. Outcomes such as length of stay, time from referral to admission etc. vary between the services; as do practices such as admission and discharge planning.
**PDoC and Tracheostomy Patients**

Due to national recommendations developed since 2013 for managing/assessing neurological patients with PDoC and/or tracheostomy in minimum cohorts to ensure appropriate expert care, such patients who require post-acute inpatient rehabilitation are not managed in the four post-acute units. Because of the complex needs of these patients, clinicians managing them must have appropriate specialist skills and the infrastructure to support safe patient care.

Consequently, in GM patients with PDoC and/or tracheostomy who require post-acute rehabilitation are directed towards independent sector placements and remain in acute Neuro-Rehabilitation beds whilst the process to agree and find a placement is completed. In addition, these low volume/complex placements are monitored by commissioning organisations who may not have access to the relevant expertise and rely solely on the assessments and advice supplied by the providers. For these reasons patients often remain in independent sector beds for many months longer than clinically required.

As detailed within the Acute Neuro-Rehabilitation Case for Change, commissioners have agreed to the non-recurrent funding of a complex discharge team to provide the bridge between acute and community services, which will contribute to the Model of Care.

*Figure 1 Current model of Neuro-Rehabilitation services in GM*

**Other Independent Sector Provision**
There are no routinely commissioned slow stream Neuro-Rehabilitation services in GM, or any routinely commissioned post-acute services for people with Severe Challenging Behaviour (SCB); instead, individual funding requests are made and placements arranged on an ad hoc basis with multiple providers, both within and out-with GM.

The GM CCGs currently spend c. £6.2 million per annum (2018/19) on slow-stream Neuro-Rehabilitation placements. The number of placements and costs are increasing year on year with the equivalent spend in 2016/17 being £4.5 million. The spend on post-acute services for people with SCB is currently unquantified. However, all people are placed outside of GM due to the lack of specialist facilities within the region. Due to a of lack of expertise of commissioners in the long term management of these complex patients, alongside absence of pro-active clinical monitoring of placements, it is not known what proportion of patients remain in costly inpatient settings for longer than is clinically required, contributing to a delayed patient recovery.

**NHS Community Services**

Significant work has already been completed in developing a standardised service specification for community neuro rehabilitation services and commissioners have started the process of commissioning/delivery of that service specification; there are currently four areas that have commissioned services to the specification (North Manchester, Stockport, Salford and Heywood, Middleton and Rochdale), two of which (North Manchester and Stockport) are now delivering to the specification and the other two are in implementation. The current status of community services was confirmed at GM Directors of Commissioning (DoCs) meeting in May 2019 and the assurance of each locality’s commitment to the community specification is contained in appendix 2.

The mobilisation of community services in all localities that meet the service specification will commence by October 2019 with full mobilisation by April 2020. Full mobilisation will be required for the implementation of the acute model of care and full realisation of anticipated benefits.

**1.5 FUTURE MODEL OF CARE**

The model of care was collaboratively designed and developed following a standard design process. The model was approved by JCB in October 2018.
The key features of the Model of Care are:

- A single provider of the bed based (inpatient) GM Neuro-Rehabilitation service to:
  - Establish a single point of access to inpatient services coupled with the complex discharge service, to implement clear admission criteria and proactively manage discharges.
  - Support patients to be cared for closer to home, by reducing time spent in a hyper-acute environment.
  - Improve compliance with clinical standards and eliminate the variation.
  - Improve recruitment and retention of staff - there will be greater carer progression opportunities and improved service resilience.

- As now, up to 30 hyper-acute and acute Neuro-Rehabilitation beds on the hot site.

- In addition, up to 10 beds for the management of patients with tracheostomy and/or PDoC on the hot site (as an alternative to beds in the independent sector).

- Post-acute site/s delivering up to a total of 60 beds (27 fewer beds than the current model) with the potential to reduce bed numbers further over time.

- Circa 20 new beds for patients requiring slow stream Neuro-Rehabilitation, creating new beds closer to home for the benefits of patients.

- Community Neuro-Rehabilitation services in every locality area providing patients with a consistent service offer, regardless of postcode.
• Consistent oversight, commissioning and review of all patients in ad hoc placements in the independent sector.

• Robust and consistent pathways for patients in transition from children to adult services within Neuro-Rehabilitation.

1.6 BENEFITS AND RISKS

Benefits of the New Model of Care:

The perceived benefits outlined in the Model of Care are as follows:

Reorganisation of Post-Acute Sites and beds

• NHS sites remaining the same
• Increase in NHS bed provision
• Reduction in Independent Sector (IS) beds

This will lead to more streamlined, equitable and standardised services with opportunities for collaborative working and shared learning opportunities

Improving staffing levels to create a sustainable workforce and maintenance of competencies

The Model of Care and new tariff structure will enable staffing to be increased to British Society of Rehabilitation Medicine (BSRM) standards.

Within the Model of Care, it is expected that consistent staff competencies across the inpatient and community services will be developed to improve the quality and consistency of the service and to improve patient outcomes, thereby eliminating the current variations.

Elimination of variation in service quality, patient outcomes and involvement in Research and Development (R&D)

The Case for Change highlighted that there is significant variation in service quality, patient outcomes and indeed there is no co-ordinated access to R&D in the current Neuro-Rehabilitation service. Transforming the Neuro-Rehabilitation service in GM will create a single service, with a standardised approach to assessment, access and discharge, and provide the opportunity for a consistent approach to R&D, under the leadership of one R&D lead for the service. Services being commissioned by a single commissioning organisation will support further elimination of variation.

Consistent, high quality patient experience

The Case for Change highlighted that patient experience in GM is often poor. Feedback received to date focussed on the following themes:

• Timeliness of access to every part of the service
• Lack of services or specialists in some areas of GM
• Intensity of therapy
• Communication

The new Neuro-Rehabilitation single service will ensure equity of specialist services across GM, with standardised access to high quality care and treatment across the whole pathway of care.

Cost effective service delivery

The single service will be paid for under a consistent tariff basis as recommended nationally and in line with other English regions. Delivery of the inpatient service by a single provider will enable economies of scale and sharing of scarce resources across the service and sites.

Future-proofed services

It is vital that the recommended Model of Care in GM is future-proofed and able to deliver benefits to patients over the long-term. Anticipated future demand changes have also been factored in to the bed numbers so that the GM Single service model will remain fit for purpose.

Main Risks of the New Model of Care:

• Delivering the overall reduction of beds as described in the inpatient part of the model of care is dependent upon the transformation of community Neuro-Rehabilitation services in every area of Greater Manchester.

• Availability of workforce to recruit to new posts.

• Timescale to implement full model and the associated transformation costs incurred during phasing.

1.7 CONSTRAINTS AND DEPENDENCIES

Constraints

The pathway implementation will be subject to the following constraints:

• Patient safety is paramount and must be maintained throughout the transitional period and by the new models of service.

• Services must have robust arrangements in place to ensure that any delivery is safe and has a high quality.

• Implementation will need to be on a phased basis across Greater Manchester.

• Ability to adequately recruit to vacancies.
• Cross organisational collaboration (e.g. integrated commissioning across CCG and specialised commissioners).

• Commissioning financial constraints.

Dependencies

The successful delivery of an implementation plan will be dependent on:

• Community service provision across GM that consistently delivers and is capable of sustaining flow across the system prior to reducing bed stock

• Community services being capable of timely assessment and discharge of patients

• Service access agreements in place with host sites for INRU beds

• Successful commissioning arrangements established across all cohorts of Neuro-Rehabilitation patients across GM.

• SLAs with provider organisations in place.

• Clear understanding of current workforce arrangements across providers.

• Funding available for one-off set up costs for example estate costs and equipment costs.

1.8 MODEL OF CARE ASSURANCE PROCESS

The Model of Care (accompanied by the quality standards and co-dependency framework) was independently reviewed by an External Clinical Assurance Panel (ECAP) and feedback from this process contributed towards the final Model of Care recommendation in 2017. ECAP confirmed that models for hyper acute and acute services would work from the perspective of clinical effectiveness and safety, supporting the model for co-located services.

The panel specifically noted:

• That the Case for Change was compelling and identified the appropriate drivers for change.

• That the appropriate clinical standards had been identified.

• That a good assessment of clinical interdependencies had been made.

• This Model of Care was sound with varying degrees of risks and benefits depending on the number of sites included in each model.

Panel members stated that this was the most extensive assessment of Neuro-Rehabilitation Services that they had seen, for which GM should be applauded.
The Model of Care was endorsed by the Clinical Reference Group in January 2018 and recommended by the ISCP (Theme 3) Board and Executive in April 2018.

The GM Joint Commissioning Board (GMJCB) approved the model of care and its recommendations on 16th October 2018. The GMJCB also recommended to the GM Joints Overview and Scrutiny Committee (JOSC) that formal public consultation was not required, as involvement and engagement activities proportionate to the number of patients affected by the proposed change, had been undertaken during the design process.

<table>
<thead>
<tr>
<th>Who</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner review-CCG Directors of Commissioning</td>
<td>27th November 2017</td>
</tr>
<tr>
<td>GM Neuro-Rehabilitation Operational Delivery Network Clinical Effectiveness Board</td>
<td>29th November 2017</td>
</tr>
<tr>
<td>Theme 3 External Clinical Assurance Panel</td>
<td>30th November 2017</td>
</tr>
<tr>
<td>Theme 3 Clinical Reference Group</td>
<td>31st January 2018</td>
</tr>
<tr>
<td>Theme 3 Finance and Estates Reference Group</td>
<td>20th December 2018 &amp; 7th February 2018</td>
</tr>
<tr>
<td>Theme 3 Workforce Reference Group</td>
<td>8th February 2018</td>
</tr>
<tr>
<td>Theme 3 Executive Board</td>
<td>11th April 2018</td>
</tr>
</tbody>
</table>

Table 2 Model of care assurance process

The design process was confirmed as meeting the NHSE 5 stage process and subsequently the JOSC reviewed the Model of Care in November 2018 and agreed that formal public consultation was not required.

On 19th March 2019 the GMJCB approved the recommendations of single provider and business case framework. At this meeting they also requested additional information regarding:

- Travel analysis
- Equality Impact Assessment
- Each locality’s progress on implementing the community neuro-rehab services

This information will be provided through an overarching paper to be presented at the GMJCB meeting on 18th June 2019 alongside the business case.
1.9 SINGLE PROVIDER

The approved Case for Change and Model of Care recommended that the bed-based service (hyper-acute, acute, PDOC/tracheostomy, post-acute and slow stream services) would be managed as a single service by a single provider in order to integrate the whole pathway. The single service would be underpinned by:

- Single clinical leadership and governance arrangements.
- Combined medical and senior nursing workforce.
- Common standards, guidelines and protocols.
- A single research strategy (Clinical Trials).
- Combined training and education arrangements.
- With a single performance management framework.

The decision-making process to recommend the single provider was based upon the following:

- Existing GM provider of Neuro-Rehab acute services.
- Knowledge and expertise in managing Neuro-Rehabilitation patients on acute Neuroscience and Major Trauma pathways.
- Co-located with the GM Neurosciences Centre.

The recommendation to the GM Joint Commissioning Board was that the GM Neurosciences Centre (Salford Royal NHS Foundation Trust) be commissioned as the single provider for the bed-based Neuro-Rehabilitation services (hyper-acute, acute, PDOC/tracheostomy, post-acute and slow stream services) across Greater Manchester.

Salford Royal NHS Foundation Trust is an existing provider of GM Neuro-Rehabilitation Services and has the experience and expertise of managing patients within existing pathways. SRFT is also collocated with the Neurosciences centre outlined above as a key requirement of the single provider.

The GM Provider Federation Board also confirmed support for the following recommendations at its meeting on 8th March:

- Establish a single GM provider for acute and post-acute Neuro-Rehabilitation inpatient services.
- Supported, subject to due process, the designation of the GM Neurosciences Centre (Salford Royal NHS Foundation Trust) as the single service provider for GM, on that basis that given the proposed Model of Care and the consequent detailed commissioning specification that will be issued by GM commissioners (including Specialist Commissioners) Salford Royal will be the only provider capable of responding to the detailed clinical requirements.
The recommendation of the single provider and the decision-making process was approved by GMJCB at its meeting on 19th March 2019.
2. ECONOMIC CASE

2.1 INTRODUCTION

The economic case describes the agreed key model of care components and how this was utilised to undergo a high-level options appraisal undertaken by the programme team and patient and carer group. The single provider has taken this work to refine the available options and outline a preferred option. This case also outlines the critical success factors required to implement the preferred option and the expected benefits.

2.2 MODEL OF CARE COMPONENTS

The model of care in line with ISCP Finance and Estates Reference Group financial principles recommended the following configuration of beds within the model:

**Hot Site(s):**

- Up to 30 hyper-acute and acute Neuro-Rehabilitation beds on the hot site.
- In addition, up to 10 beds for the management of patients with tracheostomy and/or PDoC in accordance with the co-dependency framework (as an alternative to beds in the independent sector).

**Cold site(s):**

- A total of 60 beds for post-acute Neuro-Rehabilitation (27 fewer beds than the current model) with the potential to reduce bed numbers further over time.
- A slow stream unit (circa 20 beds) within GM to ensure care is provided closer to the patient’s home.
- This configuration would be supported further by:
  - Community Neuro-Rehabilitation services in every locality area providing patients with a consistent service offer, regardless of postcode; and
  - Consistent oversight, commissioning and review of all patients in ad hoc placements in the independent sector.
2.3 MODEL OF CARE: OPTIONS APPRAISAL

A high-level options appraisal was undertaken using information collected from the case for change and model of care by both the Neuro-Rehab Programme Group and Neuro-Rehab Patient and Carer Group against the following categories:

- Quality of Care
- Access to Care
- Patient and Carer Experience
- Value for Money
- Deliverability
- Strategic Fit

Following appraisal the following options were preferred:

- PDoC/Tracheostomy provided at Salford Royal site
- 5 Slow-Stream PDOC/Tracheostomy beds at Floyd Unit
- 10 Slow-Stream Physical beds at Floyd Unit
- 5 Slow-Stream Behavioural/Cognitive at Devonshire Unit
- 15 Post-Acute Beds at Devonshire Unit
- 5 Post-Acute Beds at Floyd Unit (not challenging behaviour)
- 40 Post-Acute Beds at Trafford

In developing the business case the recommended single provider Salford Royal Foundation Trust (SRFT) used this high-level options appraisal information to develop and evaluate 3 options based on the previous work. These were:

1. Do nothing
2. Adopt the GM model of care minus provision for PDOC/Tracheostomy patients
3. Adopt the full GM model of care

These were appraised as outlined below:

<table>
<thead>
<tr>
<th>Options Description</th>
<th>Main Advantages</th>
<th>Main Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1: Do nothing - continue as current</td>
<td>No change of employer for staff currently working in the service</td>
<td>No improvement to patient flow resulting in continued acute bed blocking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Trust would not access the increased Tariffs if it did nothing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People would continue to not have the right care, in the right place, at the right time and hence their outcomes would not improve</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings from improving patient flow will not be realised</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The service will continue to not be able to provide the intensity of therapy that patients need and length of stay will therefore not be reduced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There would continue to be inequity of service provision across GM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People would continue to receive slow-stream rehabilitation in the independent</td>
</tr>
</tbody>
</table>
### Option 2: Partly adopt the GM Neuro-Rehabilitation Model of Care, excluding the PDoC/Tracheostomy

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-off cost to create 10 PDoC/Tracheostomy beds/ward would be saved</td>
<td>Continued bed blocking relating patients with PDoC and/or Tracheostomy, impacting upstream services e.g. neurosurgery</td>
</tr>
<tr>
<td>Would not have to invest funds/time/resources to train more staff to manage PDoC/Tracheostomy patients</td>
<td>Single provider would not be delivering on the model of care i.e. being the provider for all of the inpatient neuro-rehab beds in the model of care, as the post-acute PDoc/tracheostomy patients would still have to be referred to independent sector</td>
</tr>
<tr>
<td>Improved patient flow for all patients except PDoC/Tracheostomy</td>
<td>Experience of PDoC/Tracheostomy patients and their families does not improve (have to wait long time to access acute services and independent sector for post-acute)</td>
</tr>
<tr>
<td>Costs associated with delayed discharges will reduce for all inpatient neuro-rehab beds with the exception of PDoC/Tracheostomy</td>
<td></td>
</tr>
<tr>
<td>Improved standardisation and consistency of the GM inpatient Neuro-Rehabilitation services, with the exception of post-acute PDoC/Tracheostomy</td>
<td></td>
</tr>
</tbody>
</table>

### Option 3: Adopt the full GM Neuro-Rehabilitation Model of Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circa 20 new beds for patients requiring slow stream Neuro-Rehabilitation, creating new beds closer to home for the benefits of patients</td>
<td>Success of the new model is dependent on the consistent provision of community Neuro-Rehabilitation services in every locality</td>
</tr>
<tr>
<td>Up to 10 new beds for the management of patients with tracheostomy and/or PDoC on the hot site (to provide improved patient choice of care, closer to home)</td>
<td>Additional bed capacity will need to be identified to accommodate the PDoc/Tracheostomy patients</td>
</tr>
<tr>
<td>Post-acute site/s delivering up to a total of 60 beds (27 fewer beds than current</td>
<td>Estate costs</td>
</tr>
</tbody>
</table>
model) with the potential to reduce bed numbers further over time
Improved patient flow, resulting in reduced LOS and improved patient experience
Workforce resilience
Improved consistency and standardisation of the whole of the Neuro-Rehabilitation inpatient service
The agreed GM model of care would be fully implemented
Implementing the GM model of care would attract higher bed day tariffs for every level of the service, thereby enabling the service to meet national staffing levels.

Table 4 Options Appraisal

2.4 PREFERRED OPTION

The preferred option as modelled within the financial case is option 3, adopt the full GM model of care. Adopting the full model would help reduce variation that currently exists across service and support improving patient flow, reducing length of stay and overall improving patient experience.

2.5 CRITICAL SUCCESS FACTORS

In order for the Model of Care to be implemented successfully there are a number of critical success factors that need to be addressed:

Community Neuro-Rehabilitation as the key ‘enabling’ component in the Model of Care

For the inpatient services to be able to reduce the number of post-acute beds, there must be Community Neuro-Rehabilitation services in every area of GM. Community Neuro-Rehabilitation services are critical to the success of the Model of Care, as well as future proofing the service. Without this provision, beds cannot be closed and the service will not achieve right care, right time and right place. The challenge associated with regards to community services is the level of investment required by some CCGs – primarily those CCGs with no service currently or with a very low staffing base. However, the only alternative to investing in community services is further investment and commissioning of bed based services in both the NHS and independent sector.

Governance

To ensure a whole-system approach and an effective single Model of Care for Neuro-Rehabilitation, it is essential that there is a shared governance framework across the acute and community sectors. The governance framework will ensure robust clinical governance, effective coordination of services and communication and will foster collaboration and innovation.
Audit of existing patients in the independent sector

GM CCGs have recently agreed to allow clinical ODN leads to review all patients currently in the independent sector. This will enable an accurate assessment and care plan review for each of these patients and will enable validation of the current bed number estimates for slow stream and PDoC/tracheostomy patients.

Developing a greater understanding of the needs of people currently placed within independent sector slow-stream rehabilitation placements is critical to more accurately describing the future service requirements for slow stream rehabilitation.

Engagement with Neighbouring Localities

Further engagement about the developing Model of Care is required with neighbouring commissioners to GM; this is particularly relevant for North Derbyshire and Eastern Cheshire populations who routinely access GM Neuro-Rehabilitation inpatient services.

2.6 COSTS

The financial case (section 3) gives a detailed appraisal of financial modelling and cost from both a commissioner and provider perspective.

2.7 RISKS

The key risks to implement the model of care are outlined in the table below:

<table>
<thead>
<tr>
<th>No</th>
<th>Risk</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transformation of community Neuro-Rehabilitation services is not complete in time for implementation</td>
<td>Full benefits of model cannot be realised. Patients within an acute setting but fit for discharge into community care remain in an acute setting where community services are not established.</td>
</tr>
<tr>
<td>2</td>
<td>Availability of workforce to recruit to new posts</td>
<td>New model cannot be implemented and service does have staff to meet requirements or service specification. Single provider incurs agency costs to fill posts</td>
</tr>
<tr>
<td>3</td>
<td>Future intentions of use of estate</td>
<td>Organisations owning estate where the service will be delivered from may decide to change the use of that estate or give up estate therefore impacting the service to deliver across GM</td>
</tr>
<tr>
<td>4</td>
<td>Timescale to implementation</td>
<td>Timescales to implement may incur additional transformational costs that are not available therefore impacting implementation</td>
</tr>
</tbody>
</table>

Table 5 Key Risks
The identification and management of risks is further detailed in the management case (section 5.8)

2.8 BENEFITS

The key benefits outlined in the model of care are illustrated below:

Figure 3 Key Benefits of the Model of Care

The anticipated financial benefits can be quantified as below:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Impact</th>
<th>Financial Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced length of stay</td>
<td>Increased flow through the service, less requirement of acute sector beds</td>
<td>Reduced Cost per patient episode</td>
</tr>
<tr>
<td></td>
<td>Patients treated in the right place at the right time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved patient experience</td>
<td></td>
</tr>
<tr>
<td>Improvement in flow management</td>
<td>Reduction in length of stay. Improved patient experience, access to MDT</td>
<td>Reduced cost per patient episode</td>
</tr>
<tr>
<td></td>
<td>Timely access to Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved patient outcomes</td>
<td></td>
</tr>
<tr>
<td><strong>Effective outpatient service</strong></td>
<td>Less outpatient appointments, reduction in waiting list, access to therapies</td>
<td>Reduction in outpatient costs</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Management of referrals in independent sector</strong></td>
<td>Less reliance on independent sector, reduction of IS beds and cost</td>
<td>Reduction in IS spend across GM</td>
</tr>
<tr>
<td></td>
<td>Reduction in length of stay in IS beds when patients do access those services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved review for patients within IS beds</td>
<td></td>
</tr>
<tr>
<td><strong>Workforce meeting national standards</strong></td>
<td>Greater intensity of rehabilitation</td>
<td>Reduced cost per patient episode</td>
</tr>
<tr>
<td></td>
<td>Access for patients to a full MDT</td>
<td>Reduction in agency costs</td>
</tr>
<tr>
<td></td>
<td>Reduced length of stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved staff morale and staff retention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved data reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved continuity of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved discharge planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved service resilience</td>
<td></td>
</tr>
<tr>
<td><strong>Improved service quality and consistency</strong></td>
<td>Improved patient outcomes</td>
<td>Reduced cost per patient episode</td>
</tr>
<tr>
<td></td>
<td>Improved patient experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in service variation</td>
<td></td>
</tr>
</tbody>
</table>

*Table 6 Benefits, Impacts and Financial Benefits*

2.9 SENSITIVITY ANALYSIS

A full sensitivity analysis is outlined in section 3.3 of the financial case.
3. FINANCIAL CASE

3.1 INTRODUCTION
This section details the overall financial case of the Greater Manchester Neuro Rehabilitation Acute redesign including commissioner financial modelling, sensitivity analysis, provider financial monitoring as well as any non-recurrent transitional costs and capital costs. The financial modelling assumes that each CCG in Greater Manchester commissions community Neuro Rehabilitation and Stroke services in line with the agreed Greater Manchester specifications for these services. The financial modelling does not include the locally determined financial investments in community services to ensure that services are commissioned in line with these specifications.

3.2 FINANCIAL MODELLING FOR COMMISSIONERS

3.2.1 Estimated Current Spend
The estimated total spend for commissioners for the current acute inpatient neuro rehabilitation pathway in Greater Manchester is £25.0m based on 2019/20 local tariffs as show in table 7. The total bed base currently is 154, made up of 117 NHS beds and 37 independent sector beds.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Level</th>
<th>Number of Beds</th>
<th>Price</th>
<th>Maximum Number of Bed Days in Year</th>
<th>Occupancy</th>
<th>Estimated Spend Based on Occupancy (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2 (SRFT)</td>
<td>1a</td>
<td>20</td>
<td>£ 505</td>
<td>7,300</td>
<td>100%</td>
<td>£ 3,668,739</td>
</tr>
<tr>
<td>B4 (SRFT)</td>
<td>1b</td>
<td>10</td>
<td>£ 609</td>
<td>3,650</td>
<td>95%</td>
<td>£ 2,117,020</td>
</tr>
<tr>
<td>Complex Discharge Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£ 349,500</td>
</tr>
<tr>
<td>PDOC / Trachy Beds</td>
<td></td>
<td></td>
<td>£ 250</td>
<td>913</td>
<td></td>
<td>£ 228,125</td>
</tr>
<tr>
<td>Floyd Unit (Rochdale)</td>
<td>2b</td>
<td>18</td>
<td>£ 441</td>
<td>6,570</td>
<td>90.0%</td>
<td>£ 2,608,298</td>
</tr>
<tr>
<td>Devonshire (Stockport)</td>
<td>2b</td>
<td>19</td>
<td>£ 421</td>
<td>6,935</td>
<td>96.5%</td>
<td>£ 2,820,335</td>
</tr>
<tr>
<td>Ward 3 (Trafford)</td>
<td>2b / 2a</td>
<td>50</td>
<td>£ 399</td>
<td>18,250</td>
<td>96.5%</td>
<td>£ 7,029,491</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>37</td>
<td></td>
<td>£ 458</td>
<td>13,428</td>
<td>100%</td>
<td>£ 6,147,607</td>
</tr>
<tr>
<td>Sub Total CCG Commissioned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£ 19,183,356</td>
</tr>
<tr>
<td>Grand Total Acute Spend</td>
<td></td>
<td></td>
<td>154</td>
<td>57,046</td>
<td></td>
<td>£ 24,969,115</td>
</tr>
</tbody>
</table>

Table 7 Estimated GM Neuro Rehab Acute Inpatient Spend 2019/20 for Commissioners

i) After the closure of the Taylor Unit in Wigan, Manchester Foundation Trust (MFT) was commissioned by Bolton and Wigan to mobilise 20 beds, however only 10 additional beds have been opened. For the purpose of this cost impact we have assumed that the 20 additional beds are operational, 50 in total.
ii) This is based on the 2019/20 contract prices in each contract.
iii) Independent sector spend is assumed the same as 2018/19.
iv) PDOC/Tracheostomy beds are an estimate of inappropriate excess bed days.
3.2.2 Estimated Future Spend

The total estimated spend for commissioners for acute inpatient neuro rehabilitation under the new model is £24.1m as shown in table 8. The total number of NHS beds increases from 117 to 120, but the new model reduces the number of Independent Sector beds required from 37 to 7. So overall there is estimated to be a reduction of 27 beds which is made up of the following changes:

- Commission 10 NHS beds for a cohort of prolonged disorders of consciousness (PDOC) & tracheostomy patients. The model expects these to be located on the hyper acute site at SRFT subject to feasibility.
- Reduce the number of Intermediate Neuro Rehab Unit beds by 27 (10 have already been realised at Trafford INRU).
- Mobilise a 20 NHS bed unit for slow stream patients, reducing independent sector commissioned beds by 30 (net reduction of 10).

The overall estimated recurrent cost impact of the new model to commissioners (excluding any non-recurrent transitional support or capital) would be £1.1m cash releasing savings, being £0.9m reduction in acute inpatient spend and a further £0.2m reduction in unnecessary outpatient follow ups. This is cash releasing savings.

For clarity, this model also assumes that this will contain future growth of an increasing trend of spend seen in the independent sector for slow stream rehabilitation. Therefore, there is a further financial efficiency relating to cost containment of £5.7m. This is discussed further in section 3.3 sensitivity analysis.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Level</th>
<th>Number of Beds</th>
<th>Estimated Price</th>
<th>Maximum Number of Bed Days in Year</th>
<th>Occupancy</th>
<th>Estimated Spend Based on Occupancy (£)</th>
<th>Cost Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyper Acute - NHS</td>
<td>1a</td>
<td>20</td>
<td>£ 646</td>
<td>7,300</td>
<td>100%</td>
<td>£ 4,695,190</td>
<td></td>
</tr>
<tr>
<td>Sub Hyper Acute - NHS</td>
<td>1b</td>
<td>10</td>
<td>£ 522</td>
<td>3,650</td>
<td>95%</td>
<td>£ 1,816,807</td>
<td></td>
</tr>
<tr>
<td>Sub Total NHSE Commissioned</td>
<td></td>
<td>30</td>
<td></td>
<td>10,950</td>
<td></td>
<td>£ 6,511,997</td>
<td>£ 726,238</td>
</tr>
<tr>
<td>PD/C Tracheostomy Patients Step Down - NHS</td>
<td>1a</td>
<td>10</td>
<td>£ 646</td>
<td>3,650</td>
<td>95%</td>
<td>£ 2,240,972</td>
<td></td>
</tr>
<tr>
<td>INRU - NHS</td>
<td>2</td>
<td>60</td>
<td>£ 488</td>
<td>21,900</td>
<td>95%</td>
<td>£ 10,152,095</td>
<td></td>
</tr>
<tr>
<td>Slow Stream - NHS</td>
<td>2</td>
<td>20</td>
<td>£ 488</td>
<td>7,300</td>
<td>100%</td>
<td>£ 3,562,139</td>
<td></td>
</tr>
<tr>
<td>Independent Sector</td>
<td>7</td>
<td>630</td>
<td>£</td>
<td>2,555</td>
<td>100%</td>
<td>£ 1,609,650</td>
<td></td>
</tr>
<tr>
<td>Sub Total CCG Commissioned</td>
<td></td>
<td>97</td>
<td></td>
<td>35,405</td>
<td></td>
<td>£ 17,564,856</td>
<td>-£ 1,618,500</td>
</tr>
<tr>
<td>Grand Total Acute Spend</td>
<td></td>
<td>127</td>
<td></td>
<td>46,355</td>
<td></td>
<td>£ 24,076,853</td>
<td>-£ 892,262</td>
</tr>
<tr>
<td>Reduce Outpatients FU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-£ 211,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-£ 1,103,262</td>
<td></td>
</tr>
</tbody>
</table>

Table 8 Estimated Recurrent Cost of Proposed Model of Care for Acute Inpatient Services

3.2.3 Modelling Assumptions and Methodology

The cost impact and beds required in the future model has been based on assumptions made around bed modelling by the clinical leads supporting the Neuro Rehabilitation project where different
interventions are estimated to impact on Length of Stay. Examples include the estimated impact that the complex discharge team and the impact of increasing the ward staffing levels to ensure more intensive support to the service users.

To note the Trafford INRU is reporting that, after implementing some of the interventions proposed in the model, the length of stay has already been reduced by up to 50% and so this presents tangible improvement in the flow of the GM system.

The proposed future bed day rate is based on the non-mandatory tariffs published in the 2019/20 national tariff. These prices were recommended by the UK Rehabilitation Outcomes Collaborative (UKROC). UKROC has confirmed that these tariffs cover the recommended staffing levels to meet UKROC standards. NHS providers are not routinely recording their activity in line with UKROC definitions and therefore this model is based on a snapshot of activity provided by the NHS providers that captures the relative complexity of patients in NHS beds at a point in time. Under the new model, it is a requirement that NHS providers need to record their activity in line with UKROC definitions in order to generate the new tariff payments.

3.2.4 Overall Estimated Cost Impact of New Model

The overall estimated recurrent cost impact of the new model to commissioners excluding any non-recurrent costs such as capital or transitional support would be £1.1m cash releasing savings, being £0.9m reduction in acute inpatient spend and a further £0.2m reduction in unnecessary outpatient follow ups. Table 9 presents the cost impact by each stage of investment and subsequent savings.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Total Full Year Recurrent Acute Cost Impact</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Invest in staffing to UKROC Recommendations (incl. Discharge Team)</td>
<td>£2,871,789</td>
<td>£2,871,789</td>
<td>£2,871,789</td>
<td>£2,871,789</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Open 10 NHS beds for PDoc/Tracheostomy</td>
<td>£2,012,847</td>
<td>£503,212</td>
<td>£2,012,847</td>
<td></td>
</tr>
<tr>
<td>Stage 3</td>
<td>Open 20 NHS Beds for Slow Stream</td>
<td>£3,562,139</td>
<td>£445,267</td>
<td>£2,226,337</td>
<td>£3,562,139</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Reduce Wasted Bed Days &amp; Close 27 INRU Beds</td>
<td>£4,538,164</td>
<td>£571,055</td>
<td>£2,855,277</td>
<td>£4,538,164</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Reduce CGG Independent Sector Spend upto 74%</td>
<td>£2,226,337</td>
<td>£1,103,262</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 6</td>
<td>Reduce neuro rehab outpatient follow ups in INRU’s</td>
<td>£221,000</td>
<td>£10,550</td>
<td>£147,700</td>
<td>£211,000</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Reduce Occupancy Rates on NHS Beds</td>
<td>£232,430</td>
<td>£11,621</td>
<td>£162,701</td>
<td>£232,430</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£1,103,262</td>
<td>£2,496,921</td>
<td>£741,055</td>
<td>£1,103,262</td>
</tr>
</tbody>
</table>

Please note that there are other non financial changes to pathway which will need to be implemented to solve flow.

1. Create a single provider model for inpatient services
2. Create a Single Point of Contact
3. Standardise Discharge Planning Protocols & Establish a Complex Discharge service
4. Each CCG area to commission a community neuro rehab service as described in GM service specification.
5. Commissioning and clinical review of Independent Sector Placements still to be confirmed with single provider.
6. Merge any separate Stroke Early Supported Discharge Teams with Community Neuro Rehab Teams.

Table 9 Overall Estimated Cost Impact of New Model by Stage and Year for Commissioners

3.2.5 Overall Estimated Cost Impact of New Model by Commissioner

It is difficult to estimate how this predicted saving will be attributed to each commissioner given that the levels of activity are relatively low for each CCG and fluctuate year on year. Therefore, to illustrate this point, 2 different cost impacts by commissioner have been calculated based on 2
different methodologies. For clarity, though, each commissioner will pay on a bed day activity basis going forward.

Table 10 shows 2 different methodologies for estimating individual CCG financial impact using the following methods:

- Methodology 1: Assume that the recurrent cost and savings associated with the new model are split across CCGs based on their populations.

- Methodology (2): Assumes that future activity by CCG will be in line with 2018/19 activity for INRU and Independent Sector. Therefore those CCGs that have a high usage of beds and spend in 2018/19 will show a larger financial benefit in this methodology.

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Total GM Cost Impact by Method (1)</th>
<th>Total GM Cost Impact by Method (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>-£174,552</td>
<td>-£179,421</td>
</tr>
<tr>
<td>Bury</td>
<td>-£107,293</td>
<td>-£98,237</td>
</tr>
<tr>
<td>HMR</td>
<td>-£122,291</td>
<td>-£82,309</td>
</tr>
<tr>
<td>Oldham</td>
<td>-£129,213</td>
<td>-£149,976</td>
</tr>
<tr>
<td>Salford</td>
<td>-£149,561</td>
<td>-£27,513</td>
</tr>
<tr>
<td>Stockport</td>
<td>-£161,516</td>
<td>-£227,442</td>
</tr>
<tr>
<td>Trafford</td>
<td>-£144,211</td>
<td>-£13,152</td>
</tr>
<tr>
<td>Wigan</td>
<td>-£334,116</td>
<td>-£111,314</td>
</tr>
<tr>
<td>T&amp;G</td>
<td>-£184,590</td>
<td>-£253,591</td>
</tr>
<tr>
<td>Manchester</td>
<td>-£318,654</td>
<td>-£422,050</td>
</tr>
<tr>
<td>GM Sub Total</td>
<td>-£1,625,997</td>
<td>-£1,565,006</td>
</tr>
<tr>
<td>Non GM &amp; Assumption Difference</td>
<td>-£203,503</td>
<td>-£264,494</td>
</tr>
<tr>
<td>CCG Total</td>
<td>-£1,829,500</td>
<td>-£1,829,500</td>
</tr>
<tr>
<td>NHSE Total</td>
<td>£726,238</td>
<td>£726,238</td>
</tr>
<tr>
<td>Grand Total</td>
<td>-£1,103,262</td>
<td>-£1,103,262</td>
</tr>
</tbody>
</table>

Table 10 Overall Estimated Recurrent Cost Impact of New Model by Commissioners using 2 different methodologies.

3.3 SENSITIVITY ANALYSIS FOR COMMISSIONERS

Due to the number of factors that could influence the financial impact of the new acute model for GM services, three scenarios have been evaluated for sensitivity analysis including a do nothing scenario, a worst case scenario and a break even scenario. Each of the scenarios reviews the assumptions that could be different to what has been modelled. There is then a summary table including the financial modelling to illustrate the different cost impact.
3.3.1 Do Nothing Scenario

The most significant increase in cost to commissioners over the last three financial years from 2016/17 is spend on independent sector slow stream placements. On average this has increased by 17.9% each year with spend in 2016/17 at £4.6m and in 2018/19 £6.1m.

Therefore, assuming no change to the acute neuro rehabilitation pathway, then the do nothing scenario assumes the Independent Sector placements and costs will continue to grow. If this trajectory of 17.9% increase per financial year continues, spend is expected to increase as per table 11 below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Increase</td>
<td>17.9%</td>
<td>17.9%</td>
<td>17.9%</td>
<td>17.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Expected IS Spend</td>
<td>£6,147,814</td>
<td>£7,248,272</td>
<td>£8,545,713</td>
<td>£10,075,396</td>
<td>£11,878,891</td>
</tr>
<tr>
<td>Increase in IS Spend Per Year</td>
<td>£1,100,459</td>
<td>£1,297,441</td>
<td>£1,529,683</td>
<td>£1,803,496</td>
<td></td>
</tr>
<tr>
<td>Cumulative Increase in IS Spend</td>
<td>£1,100,459</td>
<td>£2,397,899</td>
<td>£3,927,582</td>
<td>£5,731,078</td>
<td></td>
</tr>
</tbody>
</table>

*Table 11 Estimated Do Nothing Scenario*

3.3.2 Worst Case Scenario

The biggest investment by commissioners will be moving to the 2019/20 non-mandatory PbR tariffs for specialist rehab linked to UKROC staffing recommendations. The additional investment required in the NHS bed based model is £3.9m (stages 1-4 in table 3.2.4 referenced earlier.)

The worst case scenario is based on the additional investment in the new model but assumes the new model does not deliver the length of stay efficiencies, does not reduce the number of Independent Sector placements nor impacts on the predicted future growth of independent Sector placements. Table 12 below indicates the worst case scenario but excludes inflationary uplifts for tariffs.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in IS Spend per year</td>
<td>£2,397,899</td>
<td>£3,927,582</td>
<td>£5,731,078</td>
</tr>
<tr>
<td>Increase in Neuro Rehab Tariffs &amp; NHS Bed Base Change</td>
<td>£2,746,001</td>
<td>£2,746,060</td>
<td>£3,878,332</td>
</tr>
<tr>
<td>Total Increase in Spend on Acute Neuro Rehab</td>
<td>£5,143,900</td>
<td>£6,673,642</td>
<td>£9,609,409</td>
</tr>
</tbody>
</table>

*Table 12 Estimated Worst Case Scenario*

3.3.3 Break Even Scenario

There are various factors that could impact on the model to get a breakeven scenario however the most significant saving of the model is the estimated reduction in independent sector placements. To get a break even scenario, the new model would need to reduce spend in the independent sector by 55%. The business case assumes the new model would deliver a reduction of 74% in Independent Sector placements. From a bed numbers perspective, the break-even scenario would require a reduction from the current 37 Independent Sector placements down to 17. The business case model assumes a reduction on average from the current 37 purchased down to 7.
3.3.4 Best Case Scenario

There could also be a scenario that the benefits of the model are greater than what has been estimated. For example there could be a greater reduction in the level of beds commissioned in the independent sector. By reducing spend in the independent sector by 80% instead of the modelled 74% would mean a further reduction in costs of £0.4m.

3.3.5 Sensitivity Analysis Comparison of Scenario’s by 2022/23

Table 13 shows a summary of the cost impact of the different scenarios discussed in section 3.3 and also breaks this down between cash releasing savings and future growth containment.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Increase in Costs</th>
<th>Cash Savings</th>
<th>Future Cost Growth</th>
<th>Total Cost Impact</th>
<th>Difference to Do Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing scenario</td>
<td>£ -</td>
<td>£ -</td>
<td>£ 5,731,078</td>
<td>£ 5,731,078</td>
<td>£ -</td>
</tr>
<tr>
<td>Worst Case Scenario</td>
<td>£ 3,878,332</td>
<td>£ -</td>
<td>£ 5,731,078</td>
<td>£ 9,609,409</td>
<td>£ 3,878,332</td>
</tr>
<tr>
<td>Financial Modelled Case</td>
<td>£ 3,878,332</td>
<td>£ 4,981,593</td>
<td>£ -</td>
<td>£ 1,103,262</td>
<td>£ 6,834,339</td>
</tr>
<tr>
<td>Breakeven Scenario</td>
<td>£ 3,878,332</td>
<td>£ 3,878,332</td>
<td>£ -</td>
<td>£ -</td>
<td>£ 5,731,078</td>
</tr>
</tbody>
</table>

Table 13 Estimated Scenarios

3.4 PROVIDER FINANCIAL MODEL

3.4.1 Estimated Current Provider Spend

The current estimated spend by providers on acute inpatient neuro rehab in GM is £27.2m and income is £25m. The current financial gap between income and costs is a £2.2m deficit to providers as shown in table 14 below.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Level</th>
<th>No Of Beds</th>
<th>Estimated Price</th>
<th>Maximum Number of Bed Days in Year</th>
<th>Occupancy</th>
<th>Commissioner Spend (£)</th>
<th>Provider Spend (£)</th>
<th>Difference (£)</th>
<th>Specialising Value Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2 (SRFT)</td>
<td>1a</td>
<td>20</td>
<td>£ 505</td>
<td>7,300</td>
<td>100%</td>
<td>£ 3,668,739</td>
<td>£ 4,635,578</td>
<td>£ 968,839</td>
<td>£ 483,259</td>
</tr>
<tr>
<td>B4 (SRFT)</td>
<td>1b</td>
<td>10</td>
<td>£ 609</td>
<td>3,650</td>
<td>95%</td>
<td>£ 2,117,020</td>
<td>£ 1,726,373</td>
<td>£ 390,648</td>
<td>£ 168,665</td>
</tr>
<tr>
<td>Sub Total NHSE Commissioned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Discharge Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDCC / Trachy Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Floyd Unit (Rochdale)</td>
<td>2b</td>
<td>18</td>
<td>£ 441</td>
<td>6,570</td>
<td>90.0%</td>
<td>£ 2,608,298</td>
<td>£ 3,003,105</td>
<td>£ 394,807</td>
<td>£ 400,000</td>
</tr>
<tr>
<td>Devonshire (Stockport)</td>
<td>2b</td>
<td>19</td>
<td>£ 421</td>
<td>8,635</td>
<td>96.50%</td>
<td>£ 2,820,335</td>
<td>£ 2,803,678</td>
<td>£ 16,657</td>
<td>£ 67,356</td>
</tr>
<tr>
<td>Ward 3 (Trafford)</td>
<td>2b / 2a</td>
<td>40</td>
<td>£ 399</td>
<td>14,600</td>
<td>96.5%</td>
<td>£ 2,923,392</td>
<td>£ 6,777,239</td>
<td>£ 1,293,825</td>
<td>£ 492,000</td>
</tr>
<tr>
<td>Ward 3 (10 beds not operational)</td>
<td></td>
<td>10</td>
<td>£ 399</td>
<td>3,650</td>
<td>96.5%</td>
<td>£ 1,405,898</td>
<td>£ 1,405,898</td>
<td>£ -</td>
<td></td>
</tr>
<tr>
<td>Independent Sector</td>
<td></td>
<td>37</td>
<td>£ 458</td>
<td>13,428</td>
<td>100.00%</td>
<td>£ 6,149,607</td>
<td>£ 6,149,607</td>
<td>£ -</td>
<td></td>
</tr>
<tr>
<td>Sub Total CCG Commissioned</td>
<td></td>
<td>124</td>
<td>£ 45,183</td>
<td>19,183</td>
<td>100.00%</td>
<td>£ 20,843,256</td>
<td>£ 20,843,256</td>
<td>£ 1,659,900</td>
<td>£ 959,356</td>
</tr>
<tr>
<td>Grand Total Acute Spend</td>
<td></td>
<td>154</td>
<td>£ 56,133</td>
<td>24,969</td>
<td>100.00%</td>
<td>£ 27,205,207</td>
<td>£ 27,205,207</td>
<td>£ 2,236,091</td>
<td>£ 1,611,280</td>
</tr>
</tbody>
</table>

Table 14: Current Provider Shortfall (Costs versus Income)
Note: The commissioner and provider spend has been estimated using 2018/19 actual income and spend which is then uplifted for inflation. For clarity this assumes the same financial gap between income and costs as 2018/19.

3.4.2 Future Provider Spend

The future estimated spend by providers on acute inpatient neuro rehab in GM is £25.8m and income is estimated at £24.1m. The future financial gap between income and costs is expected to be a £1.7m deficit to providers. The new model delivers £0.5m financial improvement to the provider financial position. Table 15 below shows the predicted financial position for the single provider under the new model.

3.5 NON-RECURRENT FINANCIAL COSTS

It is anticipated that the new model would be fully mobilised implemented by April 2020. At that point, the activity under the new model would be paid for under the new tariffs, which reimburse the providers for the increased staffing and costs to deliver the new model. During mobilisation, the single provider will be incurring additional costs over and above the current tariffs. The initial figures submitted estimate around £0.5m additional staffing costs would be incurred in 2019/20 as the single provider commences recruitment and mobilises the new model.

These figures are indicative and will be reviewed by commissioners and provider during implementation. Any non recurrent revenue will be considered by CCGs through GM Chief Finance Officers (CFOs).

3.6 CAPITAL REQUIREMENTS

The capital requirements to implement the new model of care for acute neuro rehabilitation is relatively small, given that the same, existing sites are being used in the future model. However,
some ward space requires re-purposing on the Salford Royal site in order meet the requirements of PODC and tracheostomy patients. This is estimated at £2.5m capital. However, this figure has not been subject to any due diligence and is being re-visited.

The availability of capital in the NHS is extremely limited. There is no capital available at a national level or at a GM level. Therefore any capital requirements should be considered as part of the provider/commissioner locality discussion. Salford Royal and Salford CCG have agreed that this level of capital requirement will be considered and approved within Salford locality.

3.7 GM FINANCE AND ESTATES REFERENCE GROUP (FERG) AGREED PRINCIPLES

The following principles were agreed by the GM Finance and Estates Reference Group (FERG) to guide each project within the Improving Specialist Care programme on the financial requirements that are expected:

- Projects are expected to demonstrate a positive recurrent revenue impact across the Greater Manchester Health/Social Care system when compared to actual current delivery. This was considered from a commissioner and a provider perspective. This condition has been met.

- Stranded costs should be minimised.

- There should be a clear distinction between cashable and non-cashable benefits. The business case shows both cash releasing and cost containment benefits.

- Financial savings should not be achieved at the expense of achieving appropriate clinical outcomes.

- All projects should seek to make best use of ALL existing estate in order to minimise costs.

- The use of empty/under-utilised estate where costs are fixed/have already been committed should be a priority.

- No projects should be granted capital to build new hospital estate unless either existing estate is appropriately utilised or building new estate is demonstrably better value for money that repurposing existing empty estate.

The GM Provider DoFs, GM CFOs and the GM FERG chair considered this case in light of the FERG principles and concluded that the FERG principles have been met given that the new model of care delivers a positive improvement in the revenue financial position (from both commissioner and provider perspective) and that stranded costs had been minimised, predominantly as a result of using existing estates and locations.

Further work is required to understand and agree how costs and funding are moved around the system as a consequence of implementing a single provider model. This work will be picked up as part of the Improved Specialist Care Programme (ISCP) as this will be an issue for all models of care.
4. COMMERCIAL CASE

4.1 INTRODUCTION

This section outlines the process undertaken to identify the single provider and how charging and contracting mechanisms and personnel implications will be managed during and following implementation.

4.2 PROCUREMENT STRATEGY

The approved Case for Change and Model of Care recommended that the bed-based service (hyper-acute, acute, PDOC/tracheostomy, post-acute and slow stream services) would be managed as a single service by a single provider in order to integrate the whole pathway. The single service would be underpinned by:

- Single clinical leadership and governance arrangements.
- Combined medical and senior nursing workforce.
- Common standards, guidelines and protocols.
- A single research strategy (Clinical Trials).
- Combined training and education arrangements.
- With a single performance management framework.

The decision-making process to recommend the single provider was based upon the following:

- Existing GM provider of Neuro-Rehab acute services.
- Knowledge and expertise in managing Neuro-Rehabilitation patients on acute Neuroscience and Major Trauma pathways.
- Co-located with the GM Neurosciences Centre.

The recommendation of SRFT as the single provider and the decision-making process was endorsed by GMJCB at its meeting on 19th March 2019. The decision to award the contract of NHS Acute Neuro Rehab provision to SRFT will be published on contract finder and there will be clarity given to existing providers that under the GM Acute Neuro Model there will still be the need for spot purchase placements with independent sector providers where appropriate. It is also suggested that this information is published on each GM CCG’s procurement and contracts register that should be on each CCG’s website.
4.3 CHARGING MECHANISMS

As a result of the redesigned model all of the Greater Manchester Neuro Rehab NHS provision will be commissioned via Salford Royal. Currently NHS provision is commissioned with Salford Royal FT, Manchester FT, Stockport FT and Pennine Acute.

There are two NHS standard contracts that will span the breadth of these commissioned NHS neuro rehab services with SRFT; the CCG contract where Salford CCG is the lead commissioner and the NHSE Specialist Commissioner contract. Both contracts will be varied and the charging of activity going forward will be as per the arrangements currently in place for both these contracts.

4.4 CONTRACTUAL ISSUES

As per charging mechanism all of the Greater Manchester Neuro Rehab NHS provision will be commissioned via Salford Royal. Therefore, any contractual issues that arise going forward linked to Neuro Rehab will be dealt with using the current principles and processes in place of the two existing NHS standard contracts in place with CCG’s and NHSE Specialist Commissioners.

However, due to the significant change it is expected that there will a separate commissioner / provider monitoring of implementation and ongoing service provision for acute neuro rehab.

4.5 PERSONNEL IMPLICATIONS

Across the current service there are currently approximately 185 WTEs of staff across all disciplines. Not all of these positions will be directly affected, during implementation they will be reviewed with affected staff either transferring by TUPE to the single provider or SLAs set up to ensure quality and safety of service continues. Staffing levels in the new model will be established to meet BSRM guidelines and clinical standards. The single provider will work with GM workforce group to ensure compliance with established HR policies.
5. MANAGEMENT CASE

5.1 INTRODUCTION

This section describes the structures and processes for the programme management arrangements to ensure robust management throughout the life-cycle of the programme. This will then provide an established governance structure to support the service following implementation and during business as usual.

The governance arrangements have been designed to build on the work of the programme-to-date and to support a number of key principles:

- Maintenance of safety through transition will remain paramount.
- Maintaining strong clinical leadership through a clinically led process, to ensure that clinicians and decision makers can be confident that changes can be made safely and sustainably.
- To have clear points of accountability for all key deliverables.
- Driving change through local/business as usual arrangements where possible, with centrally controlled activity/intervention only where necessary.
- Remaining transparent and open to scrutiny from Local Authorities, patients and the public.
- Remaining aware of the patient, carer and community voice on all decisions that impact on their experience, taking into account protected groups, disadvantaged groups and carers.
- Providing assurance that the anticipated benefits of the programme will be delivered.

5.2 PROGRAMME GOVERNANCE AND MANAGEMENT

The implementation will be overseen by a steering group consisting of key stakeholders involved in the transformation programme. This group will take the place of the existing Neuro-Rehab Programme board and will report directly into the Improving Specialist Care Programme (ISCP) Board, as part of the formal governance of GMHSCP. The governance structure is illustrated below:
The membership and purpose of the key groups and boards are described below:

<table>
<thead>
<tr>
<th>Group</th>
<th>Membership</th>
<th>Summary Purpose</th>
</tr>
</thead>
</table>
| **Improving Specialist Care Implementation Board** (Monthly) | Improving Specialist Care Executive Lead  
Provider Executives  
Commissioner Executives  
Local Authority Representative(s)  
Finance and Estates Representatives, GP Provider(s), Patient representative(s)  
Clinical representative(s), Other ‘Theme’ leads and enabling work stream leads | Oversee and assure the development of a long-term strategy for acute and specialised services (A&SS) across GM.  
Oversee and assure the development and delivery of the clinical models and associated strategies (workforce, estates, digital) to deliver the A&SS strategy.  
Oversee and assure the development of an options appraisal for the delivery of the A&SS strategy.  
Receive assurance that interdependencies between Theme 3 and the other Taking Charge Thematic Groups are managed.  
Manage risks and issues escalated by the Steering Group |
| **Neuro-Rehabilitation Implementation Steering Group** | Programme Lead  
Single Provider representative(s)  
Lead commissioner representative(s) | Forum for commissioners, providers and leads to manage and oversee delivery of the agreed model of care  
Develop commissioning specification to reflect new model of care |
<table>
<thead>
<tr>
<th>(Monthly during implementation)</th>
<th>NHS England (Specialist Commissioning)</th>
<th>Reporting and assurance of single service progress.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-Rehab ODN Board</td>
<td>Neuro-Rehab ODN Patient representative(s)</td>
<td>Highlight and agree management of strategic risks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide oversight for implementation readiness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Escalate risks and issues as required to Implementation Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuro-Rehab ODN board</th>
<th>Host organisation (CEO and/or Executive)</th>
<th>Facilitate, through ODN activity, high quality individualised care for patients requiring Neuro-Rehabilitation services. It will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Lead (all providers)</td>
<td>Implement strategic aims set by commissioners,</td>
</tr>
<tr>
<td></td>
<td>Operational Director (all providers)</td>
<td>Align service development to national and local priorities,</td>
</tr>
<tr>
<td></td>
<td>ODN Manager</td>
<td>Formal co-ordination of patient pathways between providers and ensure equity of service delivery to the required standards.</td>
</tr>
<tr>
<td></td>
<td>ODN Clinical Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS England Representative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCG Representative(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Local Authority Representative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Representative(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GM Neurological Alliance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuro-Rehab Project Group (Weekly during implementation)</th>
<th>Programme Lead</th>
<th>Operationally manages implementation against model of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single Provider representative(s)</td>
<td>Management of risks and issues</td>
</tr>
<tr>
<td></td>
<td>Lead commissioner representative(s)</td>
<td>Supports Steering Group</td>
</tr>
<tr>
<td></td>
<td>Neuro-Rehab ODN</td>
<td></td>
</tr>
</tbody>
</table>

**Table 14 Description of key groups and boards**

Following successful implementation, the role of the implementation steering group will change to then coordinate and support service integration of both the in-patient and community aspects of the service.

The steering group will continue to feed into the ISCP Board as required. The main focus will be:

- Oversee all elements of the Greater Manchester Neuro-Rehabilitation pathway; including delivery of the new pathway and benefits realisation.
• Set the strategic direction of the Greater Manchester pathways.
• Ensure patient and carer views are embedded into the pathway.
• Review and mitigate risks for the pathway.
• Provide direction and oversight of the sub-groups.
• Coordinate training requirements within the pathway.

Membership and terms of reference will be reviewed and revised during implementation.

Operational management and formal contractual monitoring of the inpatient elements of the service will be the responsibility of the single provider within existing commissioning arrangements.

5.3 PROGRAMME PLAN

The high-level outline plan is illustrated below. A more detailed implementation plan will be developed following acceptance of the business case and a move into implementation this will incorporate key milestones and gateway reviews and will form part of the readiness assessment to continue with implementation.

Table 15 Programme plan

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19/20 Q2</td>
</tr>
<tr>
<td></td>
<td>July/Aug/sept</td>
</tr>
<tr>
<td>Project Set-Up</td>
<td></td>
</tr>
<tr>
<td>Recruit project Team</td>
<td></td>
</tr>
<tr>
<td>IM&amp;T Scoping</td>
<td></td>
</tr>
<tr>
<td>Installation plan</td>
<td></td>
</tr>
<tr>
<td>HR Consultation process TUPE/SLA transfer</td>
<td></td>
</tr>
<tr>
<td>Floyd Unit Transfer of activity</td>
<td></td>
</tr>
<tr>
<td>Trafford Transfer of activity</td>
<td></td>
</tr>
<tr>
<td>Devonshire Unit Transfer of activity</td>
<td></td>
</tr>
<tr>
<td>PDOC / Tracheostomy Identify location</td>
<td></td>
</tr>
<tr>
<td>Location readiness</td>
<td></td>
</tr>
<tr>
<td>Service go-live</td>
<td></td>
</tr>
</tbody>
</table>
5.4 BENEFITS FRAMEWORK AND MANAGEMENT

The benefits framework outlines the methodology for collecting and reporting against different elements of the Programme. The framework describes four complementary methods of capturing progress against the process measures defined in the standards and measurement of improvements. These elements are as follows:

**Readiness Assessment** - This self-assessment tool will be used to give assurance that key and mandatory elements are in place to support ‘go-live’. The assessment will be split into sections to cover pre-live, implementation and post ‘go-live’ elements and will include the process standards developed during the design phase.

**Clinical Dashboard** - A standardised clinical dashboard will be developed to measure performance of the new service model against standards. Where possible measures will be taken from existing data sets (e.g. UKROC) to ensure ease of collection.

**Peer Review process** - An annual peer review process will be introduced utilising clinical champions. This will include site one-day visits where paper-based evidence for standards is required that are not already captured via the dashboard and readiness assessment.

**Annual Report** - Outputs from the key elements of the framework, the readiness assessments, clinical dashboards and peer review will be collated into an annual report detailing performance across GM. This report will identify performance against the keys aims of the programme.

The following table provides a summary of the benefits framework plan for the reporting and governance process through which it is reported.

<table>
<thead>
<tr>
<th>Element</th>
<th>Frequency of monitoring</th>
<th>Reporting To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readiness Assessments</td>
<td>Monthly prior to implementation</td>
<td>Implementation Steering Group</td>
</tr>
<tr>
<td>Clinical Dashboard</td>
<td>Between monthly and annually depending on measure</td>
<td>NR Services Board (once live)</td>
</tr>
<tr>
<td>Peer Review Process</td>
<td>As determined</td>
<td>NR Services Board</td>
</tr>
<tr>
<td>Annual Report</td>
<td>Annually</td>
<td>Public</td>
</tr>
</tbody>
</table>

*Table 16 Summary of the benefits framework plan for the reporting and governance process*

The approach is designed to strengthen the ‘line of sight’ between the aims of the programme, priority drivers and underpinning clinical standards. Work may be required during implementation to ensure service transformation and clinical standards are linked to benefits measurement. This has been mapped and will need refinement before ‘go-live’.
5.5 POST PROJECT EVALUATION

A full post project evaluation will be undertaken following full implementation of the model of care for programme.

At that time the evaluation will seek to deliver four key areas:

- The effectiveness of the project in realising the proposed benefits as outlined in the model of care and Business Case.

- Compare planned costs and benefits with actual costs and benefits to allow an assessment of the project’s overall value for money.

- Identify aspects of the project which have affected benefits either positively or negatively - recommendations for future projects can then be derived.

- Reveal opportunities for increasing the project’s yield of benefits, whether they were planned or became apparent during or after implementation, and to recommend the actions required to achieve their maximisation.

5.6 CHANGE MANAGEMENT AND COMMUNICATIONS

The implementation steering group will manage the organisational and cultural changes arising from the implementation of the programme. These change management processes are interwoven into the governance of the programme, the programme plan and the readiness assessment within the benefits framework.

Communication during implementation will be managed at 2 levels, internal to the single provider and external to wider Greater Manchester organisations.

Internal - There will be regular communication through team brief and in the NCA staff bulletin Connect. Regular meetings will be scheduled with staff working within Neuro-Rehabilitation wards/units to ensure they are appraised of progress.

Formal up-dates will be provided to relevant Trust Boards/Committees as per the Trust Governance structure.

External - External communication and engagement will be coordinated by the GM Health and Social Care partnership utilising existing structures including the GM Communication and Engagement Forum. The GMHSCP will also work with the Neuro-Rehab ODN to ensure consistency of message and engage with established patient networks. The engagement plan will include a multi – factorial approach to ensure the wider GM public and services are aware of the transformation.

5.7 INTERDEPENDENCIES

The programme interdependencies will be regularly considered through the Implementation Steering group in order to make best use of existing and evolving resources as the programme continues to be implemented.
The current key interdependencies are detailed below:

<table>
<thead>
<tr>
<th>Interdependency</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Neuro-rehab services</td>
<td>Consistent Community Services across GM meeting specification are required to ensure the in patient model can be implemented to ensure smooth flow of patients through the service</td>
<td>Implementation</td>
</tr>
<tr>
<td>Management of Independent Sector Placements</td>
<td>Individual CCG’s commission independent sector placements on a ‘spot-purchase’ basis. The proposed model is that SRFT as lead provider would support the placements and ongoing review including discharge options for the independent sector to maintain consistency and remove variation.</td>
<td>Design and development</td>
</tr>
</tbody>
</table>

*Table 17 Interdependencies*

Where there is a risk related to an interdependency, this is captured and managed in the risk log at Programme level and escalated as required.

**5.8 RISK MANAGEMENT**

The programme approach to risk management is embedded in the formal governance structure for Improving Specialist Care Programme. The risks and issues management framework provides a structured approach to allow enhanced strategic and business planning, and best practice approach to risk management to ensure:

- The value and benefits of risk and issue management are understood by all partners;
- Roles and responsibilities are clear; and
- Risk management is applied in the day-to-day processes.

Strategies will be in place for the proactive and effective management of risk as outlined below.

**Identification of risk and mechanisms to mitigate**

The programme has mechanisms in place to ensure all stakeholders are able to identify and flag potential risks, with review process to ensure controls to minimise the likelihood of them materialising with adverse effects.
Risks can be raised at all levels then reviewed through the Implementation Steering Group on a monthly basis. Key programme risks are managed by the programme team with designated owners and escalated and reviewed through to the Improving Specialist Care Implementation Programme Board on a monthly basis.

**Process to monitor risks**

The main programme risks are captured on a risk and issues log and are scored using a likelihood/impact matrix. Identified risks are categorised by workstream and assigned to the most appropriate person for ongoing management. The Programme Director will be responsible for ensuring that the register, including mitigating actions is updated monthly, and presented to the Improving Specialist Care Programme Board.

All single provider risks will be reviewed and managed within existing internal governance frameworks and escalated within the programme if required. The Steering Group will be able to generate actions and working groups to help resolve risks as well as ensuring shared learning across GM. In addition, meeting minutes detail any newly identified risks. Escalation of risks due to score, impact etc is through Implementation Steering Group to ISCP Board and Executive.

Key risks to the implementation have been outlined in section 1.6.
Model of Care

Neuro-Rehabilitation
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<tr>
<td><strong>Theme Lead</strong></td>
<td>Diane Whittingham</td>
</tr>
<tr>
<td><strong>Provider Transformation Lead</strong></td>
<td>Jack Sharp</td>
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<td><strong>Project Lead</strong></td>
<td>Clare Powell, Programme Director, NHS Transformation Unit</td>
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<td><strong>Author</strong></td>
<td>Hayley Michell, Senior Programme Manager, NHS Transformation Unit</td>
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**Approved by:** Kelly Bishop
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### Appendix A – Quality Standards

### Appendix B – Co-Dependency Framework

### Appendix C – Engagement Log

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<tr>
<td>BSRM</td>
<td>British Society of Rehabilitation Medicine</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CRG</td>
<td>Clinical Reference Group</td>
</tr>
<tr>
<td>DGH</td>
<td>District General Hospital</td>
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<td>ECAP</td>
<td>External Clinical Assurance Panel</td>
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<tr>
<td>FERG</td>
<td>Finance and Estates Reference Group</td>
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<tr>
<td>FY</td>
<td>Financial year (e.g. FY16 = 2015/16)</td>
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<td>GM</td>
<td>Greater Manchester</td>
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<td>GMHSC</td>
<td>Greater Manchester Health and Social Care Partnership</td>
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<td>GMNA</td>
<td>GM Neurological Alliance</td>
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<tr>
<td>INRU</td>
<td>Intermediate Neuro Rehabilitation Unit (Post-Acute)</td>
</tr>
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<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>ODN</td>
<td>Operational Delivery Network</td>
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<tr>
<td>PDoC</td>
<td>Prolonged Disorders of Consciousness</td>
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<td>PID</td>
<td>Project Initiation Document</td>
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<td>SCB</td>
<td>Severe Challenging Behaviour</td>
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<tr>
<td>SRFT</td>
<td>Salford Royal Foundation Trust</td>
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<tr>
<td>UKROC</td>
<td>UK Rehabilitation Outcomes Collaborative</td>
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1. EXECUTIVE SUMMARY

A Model of Care defines how services are organised to deliver optimal patient pathways in order to deliver improved outcomes for patients. This document describes the recommended Model of Care for Greater Manchester (GM) Neuro-Rehabilitation Services.

The Model of Care for GM Neuro-Rehabilitation (Figure 1) has been designed to meet the needs of patients and the service as described within the Case for Change Proposal by:

- Developing a single provider model with single commissioning arrangements;
- Delivering the service to agreed standards and with the agreed adjacent clinical co-dependent services;
- Implementing a complex discharge team pan-GM (already approved);
- Providing single managed care of patients with a neurological condition and a tracheostomy and/or Prolonged Disorder of Consciousness (PDoC);
- Improving commissioning arrangements for case by case patients;
- Commissioning and providing Community Neuro-Rehabilitation services according to the GM Community Neuro-Rehabilitation Service Specification in every locality of GM; and
- Developing a clinical governance structure to oversee the whole of the Neuro-Rehabilitation pathway.

Figure 1: Model of Care
The key features of the Model of Care are:

- A single provider of the bed based (inpatient) GM Neuro-Rehabilitation service to
  - Establish a single point of access to inpatient services coupled with the complex discharge service, to implement clear admission criteria and proactively manage discharges;
  - Support patients to be cared for closer to home, by reducing time spent in a hyper-acute environment.
  - Improve compliance with clinical standards and eliminate the variation;
  - Improve recruitment and retention of staff - there will be greater carer progression opportunities and improved service resilience.
- As now, up to 30 hyper-acute and acute Neuro-Rehabilitation beds on the hot site;
- In addition, up to 10 beds for the management of patients with tracheostomy and/or PDoC on the hot site (as an alternative to beds in the independent sector);
- Post-acute site/s delivering up to a total of 60 beds (27 fewer beds than the current model) with the potential to reduce bed numbers further over time;
- Circa 20 new beds for patients requiring slow stream Neuro-Rehabilitation, creating new beds closer to home for the benefits of patients.
- Community Neuro-Rehabilitation services in every locality area providing patients with a consistent service offer, regardless of postcode; and
- Consistent oversight, commissioning and review of all patients in ad hoc placements in the independent sector.
- Robust and consistent pathways for patients in transition from children to adult services within Neuro-Rehabilitation.

The Model of Care, together with the clinical, community and patient experience standards and the clinical co-dependency framework will form the basis of the Neuro-Rehabilitation inpatient service specification for GM; the community Neuro-Rehabilitation service specification has already been developed in consultation with commissioners.

This paper details the methodology and rationale for identifying the recommended Model of Care for the GM Neuro-Rehabilitation service.

## 2. Introduction and Context

### 2.1 Purpose and Objectives

Under the GM Health and Social Care Partnership’s (GMHCCP) strategic plan, the ‘Theme 3’ work stream has been established, entitled ‘Standardising Acute and Specialised Care’. As part of the Theme 3 programme, a transformation process for inpatient Neuro-Rehabilitation services commenced. Through this process, a Model of Care has been developed for the GM Neuro-Rehabilitation service.
This document describes preferences for management models for inpatient and community Neuro-Rehabilitation services, which have arisen through the engagement process to develop the Case for Change and Model of Care.

It builds upon the Project Initiation Document (PID) which was completed and signed off in November 2016 by the Transformation Portfolio Board and the Case for Change which was supported by the Theme 3 Clinical Reference Group in May 2017 and approved by the Theme 3 Executive and Board in August 2017.

The Model of Care, accompanying quality standards and co-dependency framework have been reviewed by an External Clinical Assurance Panel (ECAP); feedback from this process has contributed towards the final Model of Care recommendation.

In summary, the ECAP confirmed that both models for hyper acute and acute services would work from the perspective of clinical effectiveness and safety with the balance of preference toward the model presenting co-located services. For post-acute services, the panel would confirm the proposed direction of travel towards rationalisation of numbers of beds and sites.

The panel specifically noted:

- That the Case for Change is compelling and identifies the appropriate drivers for change.
- That the appropriate clinical standards have been identified.
- That a good assessment of clinical interdependencies has been made.
- This Model of Care is sound with varying degrees of risks and benefits depending on the number of sites included in each model.

Panel members went onto agree that this is the most extensive assessment of Neuro-Rehabilitation Services that they have seen, for which GM should be applauded. The success of the new Model of Care for Neuro-Rehabilitation will be significantly dependent on the out-of-scope community service model. The scope of the proposed Model of Care is narrowly based on brain injury patients rather than progressive or congenital neurological conditions. Further work may therefore need to be undertaken to ensure that these key patient groups are not neglected, especially if community services are not addressed.

2.2 The Current Model of Care

Neuro-Rehabilitation services provide rehabilitation for patients with neurological illness, injury or long-term condition in the hyper-acute, acute, post-acute, slow stream or community setting. In GM, the services are currently configured as described below and in Figures 2 and 3.

**Hyper Acute and Acute Neuro-Rehabilitation Services** are currently provided as part of the GM Neurosciences Centre and co-located Major Trauma Centre at Salford Royal Foundation Trust (SRFT).

**Post-Acute Neuro-Rehabilitation Services** are provided by four NHS Trusts and commissioned individually by four Clinical Commissioning Groups (CCGs).
Each of the NHS inpatient services are managed by a different Trust and commissioned separately. Outcomes such as length of stay, time from referral to admission etc. vary between the services; as do practices such as admission and discharge planning.

From 1 April 2018, the service provided by Wrightington, Wigan and Leigh NHS Foundation Trust at the Taylor Unit in Leigh will no longer be provided; instead the beds will be recommissioned and provided elsewhere. A final decision about the recommissioning of the service is expected shortly.

**Figure 2: Location of current GM Neuro-Rehabilitation Services**

PDoc and Tracheostomy Patients

Due to national recommendations developed since 2013 for managing/assessing neurological patients with PDoc and/or tracheostomy in minimum cohorts to ensure appropriate expert care, such patients who require post-acute inpatient rehabilitation are not managed in the four post-acute units. Because of the complex needs of these patients, clinicians managing them must have appropriate specialist skills and the infrastructure to support safe patient care.

Consequently, in GM patients with PDoc and/or tracheostomy who require post-acute rehabilitation are directed towards independent sector placements and remain in acute
Neuro-Rehabilitation beds whilst the process to agree and find a placement is completed. In addition, these low volume/complex placements are monitored by commissioning organisations who may not have access to the relevant expertise and rely solely on the assessments and advice supplied by the providers. For these reasons patients often remain in independent sector beds for many months longer than clinically required.

As detailed within the Neuro-Rehabilitation Case for Change, commissioners have agreed to the funding of a complex discharge team to provide the bridge between acute and community services, which will contribute to the Model of Care.

**Figure 3: Current Model of Neuro-Rehabilitation Services in GM**

**Other Independent Sector Provision**

There are no routinely commissioned slow stream Neuro-Rehabilitation services in GM, or any routinely commissioned post-acute services for people with Severe Challenging Behaviour (SCB); instead, individual funding requests are made and placements arranged on an ad hoc basis with multiple providers, both within and out-with GM.

The GM CCGs currently spend c. £4.5 million per annum on slow-stream Neuro-Rehabilitation placements. The spend on post-acute services for people with SCB is currently unquantified, however all people are placed outside of GM due to the lack of specialist facilities within the region. Due to a lack of expertise of commissioners in the long term management of these complex patients, alongside absence of pro-active clinical monitoring of placements, it is not known what proportion of patients remain in costly inpatient settings for longer than is clinically required, contributing to a delayed patient recovery.
NHS Community Services

The provision of Community Neuro-Rehabilitation services in GM varies significantly. Two areas do not currently have a service (Bury and South Manchester) and of the ten areas that already have a service, only the North Manchester community Neuro-Rehabilitation service meets the community Neuro-Rehabilitation service specification.

Within the remaining nine services there are particular issues with:

- Long waiting times to access the service (this can be many months);
- Lack of access to certain uni-professionals (some will only accept patients requiring a minimum of 2 disciplines);
- Lack of capacity to in-reach to draw people out of hospital;
- Lack of capacity to provide daily therapy.

The impact of these service issues on patient outcomes is that individuals may not reach their potential, may take longer to do so and some may deteriorate physically and psychologically whilst waiting to access the service.

It is imperative the Model of Care, together with the clinical, community and patient experience standards and the clinical co-dependency framework forms the basis of the Neuro-Rehabilitation inpatient service specification for GM.

2.3 The Case for Change

The key drivers for change in the inpatient Neuro-Rehabilitation are:

- **Patient flow is inadequate, inequitable and disjoined across the system.** There is a lack of appropriate and timely access to beds and to community services with uncoordinated access to care at all levels. Admission and discharge criteria for all levels of neurological rehabilitation require strengthening to minimise blockages and to overcome barriers to appropriate care, to ensure patients are in the right setting for their rehabilitation need. Blockages in Neuro-Rehabilitation beds alone amount to c. 9000 lost bed days and c. £3 million per annum. In addition, people spend c. 8000 bed days in other GM NHS beds (i.e. in District General Hospital (DGHs)) per annum, waiting for a GM Neuro-Rehabilitation bed. Appropriately resourced services need to be commissioned to meet demand and avoid the current waste in the system.

- **Inadequate care and flow for tracheostomy (due to neurological deficits) and PDoC patients** because the current post-acute Neuro-Rehabilitation services are not able to meet national standards for both tracheostomy and PDoC patients. Those patients requiring ongoing rehabilitation after medical stabilisation can wait for prolonged periods of time in acute beds waiting for a commissioning decision and independent sector placement.

- **Poor access to post-acute Neuro-Rehabilitation.** There is no directly commissioned service for slow-stream rehabilitation or medically stable Neuro-Rehabilitation patients who display SCB and require post-acute services. Instead individual funding requests are
submitted and considered by CCGs and ad hoc placements arranged both within and outside of GM, mainly within the independent sector. GM CCGs spend approximately £4.5 million per year on slow-stream rehabilitation placements, contracting with multiple different providers. Frequency of reviews of patients within these placements varies between CCGs and anecdotally, commissioners have expressed concern about patients spending too long in independent sector placements and whether they have the expertise in Neuro-Rehabilitation to review placements.

- **Variations in care and service provision:**
  - **Post Acute services vary**, including waiting times to access the services, practices within services including admission and discharge planning, staffing levels, outcomes, key performance indicators e.g. average length of stay varies between post-acute services (88 days – 156 days).
  - **Community services vary** as described earlier and this creates unacceptable inequalities in access to care. The impact of inadequate community Neuro-Rehabilitation services includes longer lengths of stay for some inpatients, people are admitted to inpatient services inappropriately, sub optimal patient outcomes and, in some cases, failure to reach individual potential and poor patient experience.

- **Tariff varies between inpatient services both within GM and with neighbouring services.** Within GM, the post-acute Neuro-Rehabilitation service bed day rates vary from £385 to £426 per day. **Level 1** are high cost / low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements. These services are sub-divided into: **Level 1a** - for patients with high physical dependency and **Level 1b** - mixed dependency. The tariff for the level 1a service in GM is £487, significantly lower than the equivalent service in Cheshire & Merseyside which has a bed day rate of £550. The level 1b service in GM is funded to a higher level (£587) than the equivalent level 1b service in Cheshire & Merseyside (£550). The current tariff in GM does not enable the service to operate with sufficient staff and is one of the primary root causes of the service difficulties.

- **Significant variation in investment in Community Neuro-Rehabilitation services between different regions of GM.** The low levels or lack of investment in community neuro-rehabilitation services does not allow the service to operate with sufficient staff and is one of the primary root causes of the service difficulties described earlier.

- **Demand for Neuro-Rehabilitation services has increased and is expected to increase further in the future. The existing service cannot meet current demand.** With advances in acute medical/surgical care, increasing numbers of patients are surviving events that they would have unfortunately died from in the past. Patients are also surviving with more complex rehabilitation and care needs. In addition, the population continues to grow and people are generally living longer.

- **Staffing levels fall significantly short of national and/or local recommendations.** This is primarily because of insufficient investment in both inpatient and community services
and results in variation between services, longer lengths of stay, sub-standard patient outcomes and experience and ultimately greater reliance and dependency of patients on other services e.g. GPs, health & social services packages of care, avoidable hospital admissions etc.

These drivers for change have informed the Model of Care design for GM. Further details on the rationale for change and background information may be found in the Case for Change summary version 1.5, 9th August 2017.

3. Model of Care Design

3.1 Model of Care

Over the last 12 months, significant work has been undertaken to determine the Model of Care for Neuro-Rehabilitation. This has included the development of new clinical standards that aim to deliver outstanding patient outcomes. It has also included structured discussions at a range of meetings and workshops, and literature reviews which together have informed the Model of Care.

Our recommendation for the Neuro-Rehabilitation Model of Care (see Figure 1) would include a single service for GM with a reduction in the current number of beds and equitable access to community Neuro-Rehabilitation services through a single commissioning agreement to prevent unnecessary admissions and to draw people out of hospital earlier than the current model. The model will support patients with a neurological condition and complex rehabilitation needs, ensuring rehabilitation in the right setting.

The definitions of the components of care included within the proposed model are show in Figure 4.
Figure 4: Levels of Neuro-Rehabilitation Service/Care Model Components

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<tr>
<td>Acute</td>
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<tr>
<td>PDoC / Trach</td>
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<td>Post-Acute</td>
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<td>Cold site</td>
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<td>Slow Stream</td>
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<td>Community</td>
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Key features:

- A single provider of the bed based (inpatient) GM Neuro-Rehabilitation service to
  - Establish a single point of access to inpatient services, coupled with the complex discharge service, to implement clear admission criteria and proactively manage discharges;
  - Support patients to be cared for closer to home, by reducing time spent in a hyper-acute environment.
  - Improve compliance with clinical standards and eliminate the variation;
  - Improve recruitment and retention of staff - there will be greater carer progression opportunities and improved service resilience;

Hot Site(s):

- Up to 30 hyper-acute and acute Neuro-Rehabilitation beds on the hot site;
- In addition, up to 10 beds for the management of patients with tracheostomy and/or PDoC in accordance with the co-dependency framework (as an alternative to beds in the independent sector);

Cold site(s):

- A total of 60 beds for post-acute Neuro-Rehabilitation (27 fewer beds than the current model) with the potential to reduce bed numbers further over time;
- A slow stream unit (circa 20 beds) within GM to ensure care is provided closer to the patients home;
- Community Neuro-Rehabilitation services in every locality area providing patients with a consistent service offer, regardless of postcode; and
- Consistent oversight, commissioning and review of all patients in ad hoc placements in the independent sector.
3.1.1 Community Neuro-Rehabilitation Model of Care

The GM Community Neuro-Rehabilitation service model has already been developed in consultation by GM commissioners and is described in the GM service specification. The key features of the service are as follows:

- A needs-led service that is person-centred rather than problem-centred by focussing on what matters to individuals and their life-plan in order to improve their quality of living and achieve their maximum potential.
- Provides a range of treatment/interventions including, but not limited to:
  - Activities to improve mobility (movement), muscle control, gait (walking), and balance.
  - Advice, education, support to improve activities of daily living, such as eating, dressing, bathing, toileting and cooking.
  - Exercise programs to improve movement, prevent or decrease weakness caused by lack of use, manage spasticity and pain, and maintain range of motion.
  - Activities to improve cognitive impairments, such as problems with concentration, attention, memory, and poor judgment.
  - Speech therapy to help patients with speaking, reading, writing, or swallowing.
  - Stress, anxiety and depression management.
  - Social and behavioural skills retraining.
  - Nutritional counselling.
  - Vocational rehabilitation assessment and intervention.
- Supports people to achieve long-term sustainable change, whenever possible.
- Supports people returning home as early as possible by in-reaching into hospital settings to draw people out of hospital and provide a seamless transition from hospital to community neuro-rehabilitation services. On discharge from hospital, community neuro-rehabilitation will commence as soon as is needed by the patient, but within a maximum of 7 days.
- Supports people to remain at home and prevents hospital admissions by providing timely intervention/treatment. Referrals will be triaged within 2 working days of receipt and people will be assessed between 1 working day and 21 days dependent upon risk. Intervention/treatment will commence on the date of assessment.
- Therapy will be provided at an intensity appropriate to individual need and at least daily, if required by the individual.
- Improves the coordination of care and reduces the impact on other NHS services by accepting self-referrals back into the service from patients/families who have previously accessed the service.
- Promotes and enhances self-management.
- Evaluates the effectiveness of the service.

At this stage, the Project Group has assumed that Community Neuro-Rehabilitation services will be provided by different providers across GM, however, to ensure community Neuro-Rehabilitation services in GM will be equitable, consistent and achieve excellent outcomes, it is recommended that:
• Community Neuro-Rehabilitation services are commissioned by a single commissioning organisation and provided according to the agreed, evidence-based GM Community Neuro-Rehabilitation Service Specification in every GM locality;
• A GM governance structure/clinical network for community Neuro-Rehabilitation is established and implemented to ensure that:
  o Services are commissioned/provided as per the specification;
  o There are consistent clinical delivery models in place;
  o High service standards are met and clinical excellence is achieved;
  o There is consistent workforce development;
  o Resources and opportunities to pool resource are optimised, for example, super-specialist regional roles such as vocational rehabilitation worker(s);
  o Regional service initiatives can be implemented e.g. regional GM community clinics.

3.1.2 Bed based (inpatient) services

It is recommended that the bed based service (hyper-acute, acute, PDOC/tracheostomy, post-acute and slow stream services) will be managed as a **single service by a single provider** in order to integrate the whole pathway. The single service will be underpinned by:

• Single clinical leadership and governance arrangements;
• Combined medical and senior nursing workforce;
• Common standards, guidelines and protocols;
• A single research strategy (Clinical Trials);
• Combined training and education arrangements;
• With a single performance management framework.

Implementation of the single service model is expected to achieve the following benefits across the whole Neuro-Rehabilitation pathway:

• Improved patient experience of care through a pathway that has been co-designed with patients and sets minimum patient experience standards;
• Improved patient outcomes linked to cohorting patients with specialist needs;
• Single point of access for managing individual patient pathways and care plans;
• Streamlined patient pathways supported by referral and treatment protocols;
• Uniformity of assessment and discharge processes / thresholds;
• Elimination of variation in care and outcomes;
• Equity of access and choice of treatment modalities/options for the GM Population;
• Implementation of best practice so that the model builds on “the best of the best”;
• Workforce economies of scale, resulting in a richer skill mix and increased development opportunities for existing staff;
• Improved recruitment and retention of specialist staff;
• Improved workforce resilience;
• Controlled and consistent adoption of evidence-based innovation including use of technology;
• Effective use of GM NHS and Social Care funding and optimised use of existing resources and infrastructure; and
3.2 Methodology for Developing the Model of Care

Significant work has been undertaken to design the proposed Model of Care for Neuro-Rehabilitation based on the achievement of quality standards that aim to deliver high class patient outcomes. Structured discussions at a range of meetings and workshops have taken place, and, combined with literature reviews have informed the Model of Care.

3.2.1 Quality Standards

A robust process has been undertaken since August 2017 to develop the quality standards for Neuro-Rehabilitation inpatient services. Appendix A details the full set of standards for Neuro-Rehabilitation including clinical standards for inpatients services, community standards and patient experience standards.

These standards have been developed through structured discussions at a range of meetings/forums with a range of stakeholder groups. Appendix C summarises the meetings and activity undertaken to develop and finalise the clinical standards and Model of Care.

The service specification for the inpatient service will be based upon the inpatient clinical standards and patient experience standards; the community standards are already reflected in the existing community service specification.

3.2.2 Co-Dependencies

The Co-Dependency Framework (see Appendix B) sets out the services that the Neuro-Rehabilitation relies upon in order to provide high quality care for patients. It is recognised that co-dependent services do not always need to be co-located on the same hospital site even though that may be desirable.

The framework differentiates between those co-dependent services that may be required immediately (and therefore must be on the same site); those which can be accessed within a given timescale; those accessed through an emergency/elective protocol, or through planned arrangements.

The key co-dependent services for the acute Neuro-Rehabilitation service, which should be immediately available and provided on the same site, are as follows:

- Access to out of hours medical support;
- Neurology;
- Mental Health Liaison Psychiatry /Neuropsychiatry out of hours on call provision from psychiatry;
- ENT with expertise in Neurologically impaired patients, including tracheostomy management;
- Speech therapists with tracheostomy expertise;
- Physiotherapists with respiratory skills/Out of hours physiotherapy;
- Radiology and imaging;
- Functional electric stimulation;
- Orthotics;
- Posture and mobility;
- Assistive technology;
- Complex discharge Team/Social Services.

3.2.3 Engagement

Appendix C details the engagement activity that has taken place in order to develop the Model of Care, standards and clinical co-dependency framework.

Key stakeholder involvement is summarised as follows:

- February - November 2016: Meetings with clinicians and commissioners to develop the GM community neuro-rehabilitation service specification.
- March 2016: Event to engage with clinicians regarding GM Neuro-Rehabilitation service proposals.
- March 2016: Events to listen to patients/families about their experiences of the service.
- September 2016: Event with patients/families to develop patient experience standards.
- June 2017: Workshop to involve clinicians, managers, commissioners in the Model of Care development.
- September 2017: Design Advisory Group involving clinicians, managers, commissioners, local authorities, patients & carers in the Model of Care development.
- 2016-17: The GM Neuro-Rehabilitation ODN Clinical Effectiveness Group developed service specifications (including standards) for each of the neuro-rehabilitation services shown in Figure 1. Each of the specifications has been agreed by the ODN Board.
- October 2017: The GM Neuro-Rehabilitation Service Transformation Project Group agreed the number of beds required in each part of the service based on point of prevalence studies.
- October 2017: The GM Neuro-Rehabilitation ODN Board ‘approved’ work so far.
- November 2017: Financial modelling has been completed based on the expected number of beds and estimates of investment required in community services by CCG.
- November 2017: The GM Neuro-Rehabilitation Service Transformation Project Group considered the options for a future Model of Care.
- November 2017: The GM Neuro-Rehabilitation ODN Patient and Carer group consulted about the potential Models of Care.
- November 2017: Full Model of Care options presented to the CCG Directors of Commissioning.
3.2.4 Patient Principles and Patient Feedback

A key principle throughout this process has been engagement and involvement of patients to ensure views and experiences influence the decision making process.

Different approaches have been used to engage with patients, carers and other key stakeholders e.g. GM Neurological Alliance (GMNA), including the following:

- Events and individual meetings with patients and families;
- Patient and GMNA representation on the Neuro-Rehabilitation ODN Board;
- Co-design workshops to develop the Model of Care;
- Patient representation on the Design Advisory Group (Oversight Forum);
- Engagement with the new Patient and Carer Group; and
- Co-design of patient experience standards.

3.2.5 Patient Experience Standards

A robust process has been undertaken to develop the patient experience standards. Patients have been involved throughout the process through listening events, as well as group and 1:1 meetings with patients and carers. The standards were developed through engagement sessions with patients, carers and clinicians in order to develop a set of standards that accurately reflect people’s experiences and ambitions for GM. The development of the patient experience standards has been an iterative process, and patients have been involved and informed of progress throughout. The principles and themes highlighted by patients and carers in the standards underpin the Model of Care and the GM service specification.

3.2.6 Review of different models

A number of Models of Care were discussed at a Design Event in September 2017, where it was concluded that the acute (requiring a hot site) and post-acute components (not requiring a hot site) were not co-dependent and therefore could be considered separately and then ‘built back together’.

The Project Group went on to discuss the different scenarios to obtain a clear view to be tested through the various models

A number of assumptions were made:

- Quality of Care - All options are expected to improve on the status quo because of the new standards. The more units there are the more likely consistent care could be compromised.
- Access - More sites would mean easier access and more choice. More sites would mean reduced ability for 7-day cover and equalities improvements.
- Patient & Carer Experience - All options would improve patient experience but some options were better than others for families and carers (related to no of sites).
• Value for Money - The capital costs and transition costs vary with the scale of the change from the status quo. There would be some economies of scale / efficiencies for the most specialist staff with reduced site numbers.
• Deliverability - Less deliverable with larger change (e.g. two acute site/one post-acute / all on one site). Opportunities for staff (training, skills development) increase with fewer sites.
• Strategic Fit - Care closer to home was considered for inpatient services; however this was largely offset as all areas are assumed to have fully commissioned community services.
• In all options, it was assumed that there would also be a slow stream unit (circa 20 beds) within GM to ensure care is provided closer to the patient’s home.

The Models of Care were then shared at the Neuro-Rehabilitation Patient and Carer Group and cross referenced against the patient experience standards. Feedback included:
• All options would improve patient experience;
• Hyper-acute, acute and post-acute PDoC/tracheostomy should be on a hot site;
• One post-acute unit would not necessarily be worse for families if it was in a central place and easy to get to; recognise that is less deliverable as would require new site / new build;
• The right expertise/specialist treatment/care is more important than where it is – people will travel for their care/their family members’ care;
• If we use the existing sites to deliver the Model of Care (including slow stream) there is an inequality North/South in terms of current capacity;
• “Thorough and intelligent work involving patients, carers, clinicians. More patient focussed than previous reviews of Neuro-Rehabilitation”;
• “Like the approach; it has looked at the service from the patient perspective”.

To support the recommend Model of Care there is a need to:
• Keep all of the most specialist care on one site;
• Limit additional capital requirements;
• Enable utilisation of all other existing sites to support co-dependency requirements as identified in the framework and
• Reduce post-acute units but there is potential to ‘free up’ to be used for slow stream patients.

3.3 Benefits of the Recommended Model of Care
The perceived benefits of the outline Model of Care are as follows:

3.3.1 Rationalisation of Post-Acute Sites
• Reducing the number of post-acute beds and sites will lead to more streamlined, equitable, standardised services with opportunities for collaborative working and shared learning opportunities. Moving to one site was felt to be less deliverable in terms of estate costs and staffing and, on the basis of using existing sites, would increase inequalities in access.
• One of the existing post-acute units could become the NHS slow stream rehabilitation unit.
• Fewer post-acute sites allows for:
  o A greater ability to cross cover and flex staffing across fewer units.
  o Better value for money in investment in more specialist equipment, without the need for duplication across multiple sites.
  o Easier to implement a standard IT infrastructure.

3.3.2 Improving staffing levels to create a sustainable workforce and maintenance of competencies
The Model of Care and new tariff structure will enable staffing to be increased to British Society of Rehabilitation Medicine (BSRM) standards¹.

It is recommended that the Model of Care will reduce the number of Neuro-Rehabilitation beds (100 compared to the 117 NHS beds currently commissioned, excluding slow stream rehabilitation services), we anticipate that only a small number of additional staff will be required to achieve the BSRM recommended staffing levels in the inpatient services.

The outline Model of Care recognises there is a gap in community staffing, however this gap cannot be quantified solely for community Neuro-Rehabilitation services, due to several of the GM Community Neuro-Rehabilitation services being combined with stroke community rehabilitation services. Individual CCGs/providers are currently reviewing current provision to determine what further service enhancements are required in order to meet both the GM Community Neuro-Rehabilitation service and stroke rehabilitation services specifications.

Within the Model of Care, it is expected that consistent staff competencies across the inpatient and community services will be developed to improve the quality and consistency of the service and to improve patient outcomes, thereby eliminating the current variations.

3.3.3 Elimination of variation in service quality, patient outcomes and involvement in Research and Development (R&D)

The Case for Change highlighted that there is significant variation in service quality, patient outcomes and indeed there is no co-ordinated access to R&D in the current Neuro-Rehabilitation service. Transforming the Neuro-Rehabilitation service in GM will create a single service, with a standardised approach to assessment, access and discharge, and provide the opportunity for a consistent approach to R&D, under the leadership of one R&D

lead for the service. Services being commissioned by a single commissioning organisation will support further elimination of variation.

3.3.4 Consistent, high quality patient experience

The Case for Change highlighted that patient experience in GM is often poor. Feedback received to date focussed on the following themes:

- Timeliness of access to every part of the service;
- Lack of services or specialists in some areas of GM;
- Intensity of therapy; and
- Communication.

The new Neuro-Rehabilitation single service will ensure equity of specialist services across GM, with standardised access to high quality care and treatment across the whole pathway of care.

3.3.5 Cost effective service delivery

The single service will be paid for under a consistent tariff basis as recommended nationally and in line with other English regions. Delivery of the inpatient service by a single provider will enable economies of scale and sharing of scare resources across the service and sites.

3.3.6 Future-proofed Services

It is vital that the recommended Model of Care in GM is future-proofed and able to deliver benefits to patients over the long-term. Anticipated future demand changes have also been factored in to the bed numbers so that the GM Single service model will remain fit for purpose.

4. Financial Modelling

4.1 Overview & Financial Principles:

This section is split up into 4 sections as follows:

- Acute Bed Modelling
- Overall Cost Impact including community and outpatients
- Capital and Transition Costs
- Risks and Sensitivity Analysis

The development of the Future Model of Care will be underpinned by the following set of principles, agreed by the Theme 3 Finance and Estates Reference Group (FERG) in September 2017.
Financial impact:

- Demonstrable positive recurrent revenue impact across the GM Health & Social care system when compared to actual current delivery.
- Stranded costs should be minimised, and a clear distinction should be drawn between cashable and non-cashable benefits.
- Financial savings should not be achieved at the expense of achieving appropriate clinical outcomes.
- To access Transformation Fund funding, be able to demonstrate a positive return on investment within four years.

Estates impact:

- Seek to make best use of ALL existing estate in order to minimise costs.
- The use of empty/under-utilised estate where costs are fixed/have already been committed should be a priority.
- Stranded capacity and associated costs should be minimised.
- Capital will not be granted to build new hospital estate unless either:
  - Existing estate is appropriately utilised; or
  - Building new estate is demonstrably better value for money than repurposing existing empty estate.

Workforce impact:

- Additional workforce costs (e.g. redundancy and re-training costs) should be kept to a minimum.
- Expenditure on non-substantive posts should be reduced in so far as appropriate.
- Agency costs should only be incurred after due consideration has been given as to whether new/vacant substantive posts should be covered by agency staff or whether it may be appropriate to delay implementation and recruit to the post substantively.

4.2 Acute bed modelling

Figure 5 below shows the current estimated acute spend for commissioners and income to providers in 2017/18 including the units.

Figure 5: Baseline Estimated Acute Spend 2017/18 for Commissioners
4.3 Driver Diagram

A Driver Diagram to articulate financial opportunities aligned to the proposed benefits of the Model of Care is currently under development.

4.4 Key Risks

The lynchpin of the Model of Care is the service specification for community neuro-rehab as this will enable the decommissioning of beds. If only a proportion of the GM CCGs commission to the agreed specification, bed based costs will remain and are likely to grow.

5. CRITICAL SUCCESS FACTORS

In order for the Model of Care to be implemented successfully there are a number of critical success factors that need to be addressed. In addition, assuming the Model of Care is approved in principle, there is further detailed work is required before moving to implementation. In particular the following issues need to be considered:

5.1 Transition from design to implementation

For the Model of Care to be successfully implemented there will be a transition period from current to future state (including project management resource to support implementation). This may include a period of ‘double running’ and will undoubtedly require dedicated project management resource to effectively deliver the change to support a detailed options appraisal exercise. The timeliness of implementation will in part be dependent upon decisions made about the management and governance of the future service. Much of the implementation could be managed directly by the single provider, however, this would rely
on a decision being made about the service leadership; the sooner a decision is made about the single provider, the sooner an implementation plan can be developed.

5.2 Governance
To ensure a whole-system approach and an effective single Model of Care for Neuro-Rehabilitation, it is essential that there is a shared governance system across the acute and community sectors. The governance system will ensure robust clinical governance, effective coordination of services and communication and will foster collaboration and innovation. During engagement events to develop the Neuro-Rehabilitation Case for Change and Model of Care, the advantages of inpatient services to be provided by a single provider has been articulated on numerous occasions. In addition, the future governance and oversight of the community service has been considered and the commissioning arrangements would benefit from further streamlining and GM oversight.

On that basis, it is recommended that:

- There is a single commissioner for all Neuro-Rehabilitation services.
- All inpatient services (hyper-acute, acute, PDoC/tracheostomy, post-acute and slow-stream services) are provided by a single provider.
- There is consistent oversight and review of all patients in ad hoc placements in the independent sector.
- A clinical network is established to oversee the delivery of Community Neuro-Rehabilitation services.
- As discussed with Directors of Commissioning, there is whole-system oversight of the clinical and service performance, to affect change and to ensure clinical and service excellence is achieved (see Figure 6 below, for a suggested governance structure).

Further work is required to define the roles and responsibilities of the single provider and commissioner.
5.3 Community Neuro-Rehabilitation as the key ‘enabling’ component in the Model of Care

For the inpatient services to be able to reduce the number of post-acute beds, there must be Community Neuro-Rehabilitation services in every area of GM. Community Neuro-Rehabilitation services are critical to the success of the Model of Care, as well as future proofing the service. Without this provision, beds cannot be closed and the service will not achieve right care, right time and right place. The challenge associated with regards to community services is the level of investment required by some CCGs – primarily those CCGs with no service currently or with a very low staffing base. However, the only alternative to investing in community services is further investment and commissioning of bed based services in both the NHS and independent sector.

5.4 Review of acute site capacity

There was a strong clinical and patient consensus that the 10 PDoC/tracheostomy beds should be co-located with the other acute beds on the hot site. The estate options will need to be reviewed.

5.5 Audit of existing patients in the independent sector

GM CCGs have recently agreed to allow clinical ODN leads to review all patients currently in the independent sector. This will enable an accurate assessment and care plan review for each of these patients and will enable validation of the current bed number estimates for slow stream and PDoC/tracheostomy patients.
Assessments of individuals within such placements has commenced, however given the scale of assessments to be undertaken (48 patients), the process will not be completed until the end of Q1 2018. Developing a greater understanding of the needs of people currently placed within independent sector slow-stream rehabilitation placements is critical to more accurately describing the future service requirements for slow stream rehabilitation.

How patients with SCB access the right services for them, in a timely manner, are not yet included in the Model of Care. There are a very small number of patients per year that fall into this category and some clinicians are reporting that fewer patients are presenting with severe challenging behaviour as a result of earlier access to inpatient Neuro-Rehabilitation services and hence timely interventions to prevent behaviour from escalating. The neuro-rehabilitation service needs to record cases over the next 12-18 months to gain further evidence for the demand for severe challenging behaviour services. In addition, NHS England need to identify GM patients with a neurological condition and severe challenging behaviour, placed within secure facilities, in order to review the needs of current patients and to determine the feasibility of creating SCB services within GM.

5.6 Estates options for post-acute and slow stream services

Detailed estate work is required to determine the best options for the location of the post-acute and slow stream Neuro-Rehabilitation parts of the service. This work will need to consider the existing estate for Neuro-Rehabilitation; optimal location of beds taking into account populations and travel times; clinical co-dependencies and the GM strategy for estate linked with other transformation work programmes. The impact of changes to site configuration on staff will also need to be considered and formal consultation and engagement may be required.

5.7 Therapeutic environment

Environmental factors need to be carefully considered and addressed for all sites and components of care. Some patients require greater amounts of space to accommodate specialist equipment and all sites will require rehabilitation gym facilities and occupational therapy areas. Some services will have a greater need for single occupancy rooms e.g. patients with PDoC.

5.8 Travel and access

Travel and access is an important consideration for patients and carers when undergoing inpatient rehabilitation. The location of post-acute and slow-stream sites need to be considered in particular in relation to the travel implications for staff, patients and visitors. Engagement with patient groups suggests patients and carers are increasingly willing to travel for specialist, high quality care. However, some clinicians expressed caution that this may not be the reality. Once potential sites are identified, detailed travel analysis, patient engagement and equality impact assessment will be required.
5.9 Engagement with Neighbouring Localities

Further engagement about the developing Model of Care is required with neighbouring commissioners to GM; this is particularly relevant for North Derbyshire and Eastern Cheshire populations who routinely access GM Neuro-Rehabilitation inpatient services. Travel analysis and equalities impact assessments will need to consider these patient populations.

5.10 Continued Development of Financial Modelling

Further work is required to understand:
- the investment required in community services to supplement existing CCG commissioned community rehab services;
- the cost of capital to deliver the Model of Care;
- the current use of slow stream services in the independent sector and the potential opportunity to provide care ‘within’ the NHS at reduced cost; and
- the impact of the Model of Care on the provider cost base.
APPENDIX A – QUALITY STANDARDS

The standards for the new Model of Care for Neuro-Rehabilitation, incorporating inpatient clinical, community and patient experience standards are attached here.

NR Standards v1.2
Final.xlsx

APPENDIX B – CO-DEPENDENCY FRAMEWORK

The Co-Dependency Framework sets out the services that the Neuro-Rehabilitation relies upon in order to provide high quality care for patients. The framework differentiates between those co-dependent services that may be required immediately; those which can be accessed within a given timescale; those accessed through an emergency/elective protocol, or through planned arrangements.

NR Co-Dependency Framework v1.1 Final.

APPENDIX C – ENGAGEMENT LOG

The approach to developing the Model of Care, standards and clinical co-dependencies has been to involve and engage stakeholders as follows:
<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting/Forum</th>
<th>Objectives</th>
<th>Invited to Attend</th>
<th>Attendees</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>21st July 2017</td>
<td>GM Neuro-Rehab ODN Board</td>
<td>Feedback to the Board about the Service Transformation Workshop in June 2017 Provide an update on the neuro-rehabilitation service transformation plans</td>
<td>ODN Board members</td>
<td>Quorate Meeting</td>
<td>• Ongoing engagement with ODN Board</td>
</tr>
<tr>
<td>10th August 2017</td>
<td>Neuro-Rehab ODN Patient &amp; Carer Group</td>
<td>Review the neuro-rehabilitation patient experience standards</td>
<td>Patients &amp; Carers who expressed an interest in joining the group, following publicity regarding the establishment of the group</td>
<td>Four patients/ carers</td>
<td>• Revised patient experience standards</td>
</tr>
<tr>
<td>18th August 2017</td>
<td>ODN core team visit to Floyd Unit</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the Model of Care</td>
<td>All Floyd Unit staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>13th September 2017</td>
<td>Neuro-Rehab Design Advisory Group meeting</td>
<td>Engage with all stakeholders to develop the neuro-rehabilitation Model of Care</td>
<td>ODN Patient &amp; Carer Group Known patients/carers GMNA ODN Board Members Neuro-rehab clinicians (community and inpatient) GM CCG Directors of Commissioning NHSE representatives Local Authority representatives</td>
<td>Board representation across all stakeholder groups. See attendance list</td>
<td>• Table discussions about Model of Care options; benefits; risks; enablers;</td>
</tr>
<tr>
<td>22nd September 2017</td>
<td>ODN core team visit to Devonshire Centre</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the Model of Care</td>
<td>All Devonshire Centre staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>Date</td>
<td>Meeting/Forum</td>
<td>Objectives</td>
<td>Invited to Attend</td>
<td>Attendees</td>
<td>Outcome</td>
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</tr>
<tr>
<td>26th September 2017</td>
<td>ODN core team visit to Trafford INRU</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Trafford INRU staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>6th October 2017</td>
<td>GM Neuro-Rehab ODN Board</td>
<td>Feedback to the Board about the Design Advisory Group Workshop in September 2017 Provide an update on the neuro-rehabilitation service transformation plans including model of care options</td>
<td>ODN Board members</td>
<td>Quorate Meeting</td>
<td>• Ongoing engagement with ODN Board</td>
</tr>
<tr>
<td>9th October 2017</td>
<td>ODN core team visit to North Manchester community neuro-rehabilitation team</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All N. Manchester CNRT staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>10th October 2017</td>
<td>ODN core team visit to Trafford community neuro-rehabilitation team</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Trafford CNRT staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>24th October 2017</td>
<td>ODN core team visit to Tameside &amp; Glossop community neuro-rehabilitation team</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All T&amp;G CNRT staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>25th October 2017</td>
<td>ODN core team visit to Bolton community neuro-rehabilitation team</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Bolton CNRT staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>26th October 2017</td>
<td>ODN core team visit to Wigan community neuro-rehabilitation team</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Wigan CNRT staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
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<tr>
<td>27th October 2017</td>
<td>ODN core team visit to Taylor Unit</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Taylor Unit staff and managers</td>
<td>Several MDT members</td>
<td>• Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>Date</td>
<td>Meeting/Forum</td>
<td>Objectives</td>
<td>Invited to Attend</td>
<td>Attendees</td>
<td>Outcome</td>
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<tr>
<td>31st October 2017</td>
<td>ODN core team visit to Central Manchester CNRT</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Central Manchester CNRT staff and managers</td>
<td>Several MDT members</td>
<td>Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
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<tr>
<td>7th November 2017</td>
<td>ODN core team visit to Oldham CNRT</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Oldham CNRT staff and managers</td>
<td>Several MDT members</td>
<td>Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
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<tr>
<td>8th November 2017</td>
<td>ODN core team visit to Salford CNRT</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the model of care</td>
<td>All Salford CNRT staff and managers</td>
<td>Several MDT members</td>
<td>Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
<tr>
<td>9th November 2017</td>
<td>ODN Patient &amp; Carer Group</td>
<td>Consider the models of care Consider model of care options against patient experience standards</td>
<td>ODN Patient &amp; Carer Group</td>
<td>5 patient/carer representatives</td>
<td>Criteria weightings amended Model of care options scored against the patient experience standards Feedback on the patient/carer engagement approach taken to date, for the neuro-rehabilitation service transformation</td>
</tr>
<tr>
<td>14th November 2017</td>
<td>GM CCG Directors of Commissioning Meeting</td>
<td>To provide an update and gain feedback on the development of the Model of Care</td>
<td>All GM CCG Directors of Commissioning</td>
<td>Directors of Commissioning</td>
<td>Ongoing engagement with GM CCG Directors of Commissioning</td>
</tr>
<tr>
<td>21st November 2017</td>
<td>ODN core team visit to Stockport CNRT</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the Model of Care</td>
<td>All Stockport CNRT staff and managers</td>
<td>Several MDT members</td>
<td>Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
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<tr>
<td>23rd November 2017</td>
<td>ODN core team visit to Salford Royal Inpatient Neuro-Rehab Services</td>
<td>Provide an overview of the GM Service Transformation Process for neuro-rehabilitation and the proposed changes which will form the basis of the Model of Care</td>
<td>All Salford Royal Neuro-Rehab staff and managers</td>
<td>Several MDT members</td>
<td>Ongoing engagement about the transformation of the GM neuro-rehabilitation service</td>
</tr>
</tbody>
</table>
APPENDIX D – FEEDBACK FROM MODEL OF CARE DESIGN EVENT

A key workshop event “Design Advisory Group Neurological Rehabilitation Model of Care” took place Wednesday 13th September 2017. The event was attended by 48 people providing representation from patient representatives, GM CCG’s, NHS England, clinicians from acute and community trusts, social services and local authorities from across GM.

The summary feedback from the event is provided in the attached presentation.
APPENDIX 2: LOCALITY PROGRESS ON IMPLEMENTING THE GM SPECIFICATION FOR COMMUNITY NEURO REHABILITATION

<table>
<thead>
<tr>
<th>Locality</th>
<th>Status at June 2019</th>
<th>Anticipated Completion of Service Specification Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>Bolton locality is working collaboratively to meet the key elements of the GM service specification which includes ensuring that the current waiting times are significantly reduced to the specification standards. Non recurrent funding has been identified to support the service redesign required. The locality is working to the revised service being operational from October 2019 but workforce to manage the current waiting list will be a challenge.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Bury</td>
<td>The CCG agreed a business case for additional investment in 2018-19 to develop an integrated stroke and neuro-rehabilitation service. The Community Stroke service exists and is well regarded and its integration with a community neuro-rehabilitation service will provide further resilience. It will be implemented in phases and mobilisation of Phase 1 will ensure compliance with the majority of the GM specification.</td>
<td>Aug-19</td>
</tr>
<tr>
<td>Heywood, Middleton and Rochdale (HMR)</td>
<td>HMR CCG has invested additional funding to ensure that community neuro rehab provision meets the GM specification and staffing structure. HMR CCG now has a Community neuro rehab (CNR) steering group that meets monthly to ensure that the CNR team continues to meet the GM specification and that wait times for the service are managed appropriately. The steering group has membership from HMR CCG planned care lead, BI, CNR team lead, clinical lead and GM Neuro rehab network. The steering group recently held a productive workshop on the pathway. The workshop was successful in identifying blockages in the service pathway and an action plan will be formed to take this forward.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>North Manchester: Completed: Business as Usual</td>
<td>Central and South Manchester: There is a designated commissioning lead in place for community neuro rehab and stroke services. A strategic outline case (SOC) will be considered by Executive committee in June 2019, setting out options and delivery costs in the context of the GM specification requirements. They are reviewing the north service and may need to prioritise resources to ensure an operational city wide community neuro rehab service. The SOC will be considered alongside other CCG priorities; the intention would be to progress to full business case in October/November 2019. The intention is for the service to be operational from April 2020 although this is dependent upon exploration and mitigation of a number of risks, including for example, recruitment and training of workforce, relevant to population need. The intended GM acute services implementation date will need to align with provider feasibility considerations in terms of community delivery, which may not be entirely ‘linear’ nor deliverable by April 2020, and which remain to be explored.</td>
<td>Completed</td>
</tr>
<tr>
<td>Manchester</td>
<td></td>
<td>Apr-20</td>
</tr>
<tr>
<td>Locality</td>
<td>Status at June 2019</td>
<td>Anticipated Completion of Service Specification Implementation</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Oldham</td>
<td>The CCG has made provision to develop existing service and will consider on receipt of a full business case. The CCG has a meeting scheduled between commissioning and service leads to further discuss the investment options and agree a final business case for submission to NHS Oldham CCG for review. To bring the service fully in line with the service specification, the CCG estimates £700K is required recurrently. There is concern that recruitment to a fully staffed service in a reasonable timescale is not realistic and a more phased, fluid solution is required that carefully monitors improvements against outcomes.</td>
<td>Not known</td>
</tr>
<tr>
<td>Salford</td>
<td>Business Case Approved with additional funding into existing teams to increase staffing and meet the GM specification; The CCG case was approved in June 2018 and the new team is almost established and operational. The CCG expects a fully established service by the end of June 2019. The service will be compliant with the GM models for stroke and community neuro rehabilitation.</td>
<td>Jul-19</td>
</tr>
<tr>
<td>Stockport</td>
<td>Completed; at Business as Usual</td>
<td>Completed</td>
</tr>
<tr>
<td>Tameside &amp; Glossop</td>
<td>The Tameside and Glossop model of care is closely aligned to the GM specification and meets all required standards. The existing service can cope with the current and projected level of demand. The Strategic Commissioners and Integrated Care Foundation Trust work closely together to monitor safety, activity levels and the effective flow of patients.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Trafford</td>
<td>The CCG has confirmed MFT as the stability partner for community services. The CCG and MFT are working through a process of due diligence which they are due to complete by October 2019. No formal decisions have been made in respect of the new community neuro rehabilitation service as yet. The CCG is starting to undertake profiling for the business case workforce modelling and it is the intention to develop the business case over the next couple of months. The CCG is assessing what can put in place, working to the timescales that the GM specification requires. A gap analysis against the specification has also been undertaken and referring to the compliance indicators from the ODN. The CCG wants to be in a position to operate the service from October.</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Wigan</td>
<td>The business case was presented to the Healthy Wigan Partnership Board for consideration and approval. The recommendation to agree the business case and progress to immediate implementation was approved. The service will be a joint community neuro rehabilitation / stroke service however it is the intention to adopt a phased approach, starting with community neuro rehabilitation in the first instance to decrease waiting times.</td>
<td>Jan-20</td>
</tr>
</tbody>
</table>
Equality Analysis Report: Theme 3: Neuro-Rehabilitation (service provision)

The report will make recommendations to the decision makers, to take into account, as part of their decision-making process.

Contents:

1. Details of service and function under review
2. Equality Act 2010 – relevant sections
3. Change to services
4. Demographics of service users
5. Differential table: Impacts and Barriers
6. Due regard and the Public Sector Equality Duty
7. Recommendation to the Committee as to whether PSED will be met.
8. Actions
1. Details of service / function/case for change:

For over a decade the service has experienced significant difficulties with patient flow and consistency of provision across Greater Manchester. Service change is required in order to achieve optimal patient outcomes.

In 2013 commissioners invested in an additional 20 beds to improve flow (10 additional level 1 beds and 10 additional level 2 beds) to bring the Greater Manchester inpatient NHS service to 117 beds. The intention, at that time, was for the provision of community neuro-rehabilitation services to be considered as a second phase after the introduction of the additional beds. In 2016 a Greater Manchester service specification for community neuro-rehabilitation was developed in collaboration with clinicians and commissioners; however there has only been a decision by one area of Greater Manchester (North Manchester) to commission and deliver a service as per the service specification. Greater Manchester has the highest number of neuro-rehabilitation beds per head of population than anywhere else in the UK.

Neuro-rehabilitation services provide rehabilitation for patients with neurological illness, injury or long-term condition in the hyper-acute, acute, post-acute, slow-stream or community services.

Hyper Acute and Acute Neuro-Rehabilitation Service is co-located with GM Neurosciences Centre and Major Trauma Centre and provided by Salford Royal NHS Foundation Trust. This specialised service is comprised of 30 beds and is commissioned by NHSE to a value of £5.8 million p.a.

Post-acute Neuro-Rehabilitation Services are provided by four NHS Trusts and commissioned by several clinical commissioning groups:

Each of the NHS inpatient services are managed by a different trust and commissioned separately, with no consistency of tariffs. Outcomes such as length of stay, time from referral to admission etc.. vary between the services; as do practices such as admission and discharge planning.

Due to national recommendations for managing/assessing neurological patients with prolonged disorder of consciousness and/or tracheostomy in minimum cohorts, patients who require post-acute rehabilitation inpatient services can no longer be managed in the four post-acute units. Instead, the patients are usually directed towards independent sector placements and remain in acute neuro-rehabilitation beds whilst the process to agree and find a placement is completed. In addition, these low volume/complex placements are monitored by commissioning organisations who may not have access to the relevant expertise and rely
solely on the assessments and advice supplied by the providers. Patient can remain in independent sector beds for many months longer than clinically required.

There are no routinely commissioned slow-stream neuro-rehabilitation services in Greater Manchester, or any routinely commissioned post-acute services for people with severe challenging behaviour, instead, individual funding requests are made, and placements arranged on an ad hoc basis with multiple different providers, both within and out-with Greater Manchester. The GM CCG spend on slow-stream neuro-rehabilitation placements is c. £4.5 million per annum. The spend on post-acute services for people with severe challenging behaviour is unknown, however all people are placed outside of Greater Manchester due to the lack of specialist facilities within the region.

The provision of community neuro-rehabilitation services in Greater Manchester varies significantly. Three areas do not have a service (Bury, North Manchester and South Manchester), however North Manchester CCG has recently commissioned a new service that will be operational from 1st September 2017. Nine areas already have a service, however there are issues with every service, such as long waiting times to access the service, lack of access to certain professionals, lack of capacity to in-reach to draw people out of hospital, lack of capacity to provide daily therapy. The impact of these service issues is that individuals either do not reach their potential or take longer to do so.

2. The Equality Act.

Any change to function, service provision or criteria that may have an effect on people would automatically be subject of the Equality Act 2010.

The parts of the acts that are ‘engaged’ (i.e. that would be active in relation to this proposal) would be:

Section 4 – protected characteristics

Section 13 - direct discrimination

Section19 – indirect discrimination

Section 20 – duty to make adjustments

Section 29 – provision of a service

Section 149 – Public Sector Equality Duty

In relation to Public Sector Equality Duty (PSED) there are three objectives that are supported by 10 subsections.

The three main objectives are:
A public authority must, in the exercise of its functions, have due regard to the need to—

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to satisfy objective A, eliminate discrimination, – sections 19 (indirect discrimination) will have to be reviewed.

In order to satisfy objective B, ‘Advance equality of opportunity’ - subsection 3 of PSED, will have to be met:

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low. of PSED

The third objective ‘foster good relations’ is not engaged in this project as the project is not one of tackling hate crime, challenging prejudice or building relationships across community and cultural boundaries.

3. Change to service:

New Model of Care

The Model of Care for GM Neuro-Rehabilitation has been designed to meet the needs of patients and the service as described within the Case for Change Proposal by:

- Developing a single provider model with single commissioning arrangements;
• Delivering the service to agreed standards and with the agreed adjacent clinical co-dependent services;
• Implementing a complex discharge team pan-GM (already approved);
• Providing single managed care of patients with a neurological condition and a tracheostomy and/or Prolonged Disorder of Consciousness (PDoC);
• Improving commissioning arrangements for case by case patients;
• Commissioning and providing Community Neuro-Rehabilitation services according to the GM Community Neuro-Rehabilitation Service Specification in every locality of GM; and
• Developing a clinical governance structure to oversee the whole of the Neuro-Rehabilitation pathway.

The significant change covers new patient’s’ services will be at different locations than they are now, and that the level of qualified staff will change, in response to meeting patients needs

4. Demographics of service users:

Unique patients by age and gender, outpatients, all service users: 2015/16-17/18
Patients by ethnicity

Distribution of patients

- This map shows inpatient neuro-rehab patients by their ethnicity and resident location.
- A high proportion of BME patients appear to be concentrated within Manchester CCG.
- This should be accounted for if service provision is intended to be moved to a different location.
- A high proportion of white patients are concentrated within Salford CCG.
5. Differential Table- Impacts and barriers

Current inpatients in post-acute sites, will not be affected by this change.

The new proposed Model of Care, for new patients will enable a deliberate and significant reduction over time in the numbers of patients who currently receive care in the independent sector. New patients in receipt of independent provider care who require 'slow stream' rehabilitation care, need care for post-acute Prolonged Disorders of Consciousness (PDoC) or tracheostomy will be cared for within the NHS in Greater Manchester.

An outcome of this proposed change will be the benefit of bringing care closer to home for patient and their families, as they will not have to travel outside Greater Manchester to private providers. Although it is recognised that some additional and extended travel will occur for some residents of Greater Manchester in traveling to the new proposed sites as some sites are changing location within Greater Manchester.

The table below is a ‘differential impact table’ which links protected characteristics to potential issues linked to travel that may affect them and their support needs.

Primary source of ‘consultation feedback’ was from ‘patient groups’.

**Differential table**

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Issue</th>
<th>Remedy/Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>age</td>
<td>The chart on page 4 shows that majority of neuro-rehab service users are aged 50 and above. There are a slightly higher proportion of male service users compared to females. Older people (in particular women/widows) are more reliant on public transport.</td>
<td>Participation by different age groups shows support for the reconfiguration. Public transport during peak time is typically used by students and commuters. Outside of this, transport users are typically women; older women and mums with children and toddlers. Older patients can mean that they have older wife/husband/partners potentially relying on public transport. Neuro-rehab: Where patients are being visited and are incurring long travel times.</td>
</tr>
</tbody>
</table>
the unit needs to support key family/loved ones in travel needs.

There is 'Health care travel costs scheme' which allows key visitors to patients to claim for 'reasonable travel cost'. The unit needs to consider how it can support key patient visits with help with costs of travel and possibly taxi fares for those who live on the boundaries of GM and are incurring long travel times.

| Disability – Linking to section 20. 'reasonable adjustments for people with disabilities.' N.B. Carers of people with disabilities are counted in the classifications of 'disability' | Carers and loved ones who have disabilities that rely on public travel will face difficulties and may have additional pressures when visiting patients. Disabilities can range from physical disability, learning disability, sensory impairment. Cancer patients are counted under the Equality Act 2010 as having a disability. Facial disfigurement is counted under the equality act 2010 as having a disability. | Particular care needs to be given for people with disabilities, visiting loved ones on the unit. Whilst many people with disabilities may have a 'blue badge' or a car through Mobility benefits, so close carparking will be necessary, not all disabled people have a private car and rely on taxis and/or public transport. People with disabilities who are new to the hospital and are visiting loved ones may find it more difficult to travel and may rely more on taxis. The unit will have to look at how it can help support disabled patients to claim for cost incurred through extra travel via the HCTRS. Similarly, if they use public transport, it may take them longer to travel on top of extended travel times, especially if it means having to change/transfer to joining buses/routes, learn new routes and to scope out new |
Loved ones visiting patients with sensory impairments (e.g. partial or non-sighted) may find the task of learning new bus routes and familiarising themselves with new buildings may be extremely difficult, they may need support in mapping out routes and how to access sites.

Visitors with learning disabilities may find they need support in route mapping and having instructions written down.

As such all this has to be taken into consideration by the unit when considering visitation, especially visitation which helps the patient along their developmental process.

The unit may have to consider special arrangements for PTS and/or HCTRS.

<table>
<thead>
<tr>
<th>Gender reassignment</th>
<th>No specific evidence available for this group.</th>
<th>No replies received where identified as coming from trans groups/patients or any group representing trans interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy &amp; maternity</td>
<td>No specific evidence available for this group.</td>
<td>No replies received were identified as coming from women who were pregnant at the time of visiting relatives in the unit or from any group that represents pregnant women’s interests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With some GM travellers facing a 2hrs public transport travel time this could have a significant impact on women who are heavily pregnant or suffering from symptoms related to pregnancy (e.g. sickness/ bladder weakness)</td>
</tr>
</tbody>
</table>
The unit may need to look at ways of supporting visits by pregnant loved ones, especially if it is integral to the patient’s recovery.

Public transport may not be an option in some instances and the unit may have to look at taxis’ reimbursement cost and where applicable look at HCTRS.

Race

BAME patients clearly show up in the service user data in patients (2015/16 & 2016/17)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Unique Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>48</td>
</tr>
<tr>
<td>Black</td>
<td>33</td>
</tr>
<tr>
<td>Mixed</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
</tr>
</tbody>
</table>

No replies received were identified as coming from BAME patients or BAME loved ones/carers visiting patients in the unit or from any group that represents BAME interests.

In relation to public transport the is risk of hate crime.

Race hate crimes on public transport nationally jumped from 1,453 to 2,566 over the five-year period¹.


Outpatients (2015/16 & 2016/17)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Unique Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>189</td>
</tr>
<tr>
<td>Black</td>
<td>46</td>
</tr>
<tr>
<td>Mixed</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
</tr>
</tbody>
</table>

Whilst Manchester is a multicultural city and proud of its multiculturalism, there are geographic areas that have large numbers of particular ethnicity/faith groups.
Religion and belief

No specific evidence available for this grouping

No replies received were identified as coming from patients or loved ones visiting patients in the unit with religious/beliefs or from any group that represents different religious and belief needs.

In relation to public transport there are risks of hate crime.

Tell MAMA\(^2\) documents 1,201 verified incidents of anti-Muslim hatred with 3,005 incidents reported over the last three years. There is a growth of Islamophobia where women wearing burqa and hijab are at a high risk of attack.

British Transport Police (BTP) figures showed faith-linked attacks on trains more than quadrupled from 64 in 2013 to 294 last year.

Spikes in hate crime were witnessed after major events such as the murder of Lee Rigby in 2013, the Brexit vote in 2016 and last year’s Manchester Arena and London Bridge attacks.

Antisemitism:

There were 727 antisemitic incidents\(^3\) across the UK in the first six months of 2018, over 100 antisemitic incidents in every one of the six months from January to June 2018.

\(^2\) ‘Beyond the incident’ - Tell MAMA 2018. These incidents took place across the UK; they are not restricted to specific regions. Most victims of anti-Muslim hatred are women and most of the perpetrators are male. A clear majority (72%) of the perpetrators are white men with younger men – including teenagers – being some of the main perpetrators.

\(^3\) CST- ‘Protecting our Jewish community’ antisemitic incidents January -June 2018.
The unit needs to support key family/friends who are fearful of using public transport to visit loved ones with help and advice/signposting to support agencies.

<table>
<thead>
<tr>
<th>Sex (M/F)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1453</td>
<td>1786</td>
</tr>
</tbody>
</table>

The patient groups had both male and female feedback.

There was support for the reconfiguration and no issue was highlighted that linked to male/female protected characteristics.

| Sexual orientation | No specific evidence available for this groups |

No replies received were identified as coming from patients or loved ones visiting patients in the unit with specific sexual orientation or from any group that represents LGBT interests.

In relation to public transport there are risks of hate crime.

The number of gay, lesbian or bisexual victims on the bus and rail network trebled from 139 to 416, over the five-year period.

6. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)

PSED section 1- Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act:
The neuro-rehab unit aims to provide professional and supportive service in line with ‘Inpatient and Community Patient Experience Standards’ to all its patients and will support any needs linked to protected characteristics.

The reconfiguration will have travel implications for those that live furthers out from the main centres. The travel analysis shows these will be minimum problems for car users, but there may be a significant lengthening of journeys for some residents of Greater Manchester who rely on Public transport.

Whilst travel to and from hospital and rehabilitation service is a necessary fact of life, for those needing such vital services, the reconfiguration has added to time to the journeys in some cases.

The extra travel can have disproportionate effect on particular protected characteristics. For example; people with disabilities and people facing potential hate crime. Also, women who are pregnant and cancer patients with urological problems may experiencing symptoms such as feeling an urgent need to urinate or a needing to urinate more often than usual will be impacted by longer travel times.

For people whose only means of travel is by public transport, where a patient is an Inpatient⁴ – family members/loved ones who may play an integral role in the patient’s rehabilitation, may be facing long and arduous journeys; patients may be inpatients for up to 12 months in some cases!

Some protected characteristics are more disadvantaged in using public transport and the additional time exacerbates their disadvantage. The decision makers have to consider whether the changes are creating unlawful indirect discrimination.

**Indirect discrimination.**

Indirect discrimination occurs when a ‘rule, criterion or practice’ is put in place such that it puts a particular protected characteristic at a disadvantage when compared to other protected characteristics.

It is clear, that some protected characteristics will face or be disadvantaged, but this does not necessarily amount to indirect discrimination due to the following factors:

a) Section 19 subsection (2) (d) of the Equality Act 2010 states; ‘[indirect discrimination does not occur] when [the decision makers] can show [the action it wishes to take] is a proportionate means of achieving a legitimate aim.

The legitimate aim here is to ensure people have access to a strong, fit for purpose neuro-rehabilitation service. There is a clear case for its reorganisation. If the decision makers are satisfied that it has tried everything within its power to keep the more local provision, and of which cannot reach the necessary and desired standard,

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⁴ Where a patient is an out-patient – PTS, section 9, allows for a carer to travel with the patient
such that the only recourse is the reorganization as presented, then the Committee has demonstrated a ‘proportional means’. Therefore, it is unlikely that indirect discrimination would apply.

b) The decision makers recognises that some people will be disadvantages in their travel arrangement, however the neuro-rehab unit will help support patients with PTS and their carers/visitors with Heath Care Travel Cost Scheme, especially those with disabilities, and to try and help minimise the impact of travel on those that are at the extremes of journeys and journey times. As such the issue of the impact of travel will be reduced therefore, indirect discrimination has been mitigated against

c) There is a recognition, whilst not directly tested with the community, that residents often travel to visit post offices, banks, hospital, shopping centres and other amenities such as parks/libraries/schools. ‘Having to travel further than before’, inculcates the notion that one can travel. Travelling further or for longer may be inconvenient but this is not the same as being discriminated against.

The neuro-rehab unit moving forward needs to monitor ‘patients and key visitors’ travel arrangement and understand the dynamics of how people travel, and the impact of travel has on them. It may be the case that in reviewing the details:

   a) the unit is satisfied that there is no major disadvantage and that help, and support is available, and this help and support helps minimise impact of travel,

or

   b) recognise that there might be major impact that is currently unperceived that PTS and HCTCS would not help mitigate and that the unit looks into the issue of funding/financing some form of transport service for carers facing the extremes of travel arrangements. (see section PSED objective 2(3(c)) below)

**PSED 1, Objective 2; Advance Equality of opportunity**

The unit will make individual assessment of the person’s need and develop models of support around the medical and the personal need.

As the person travels through the medical stages, full consideration will be given to their needs linked to protected characteristics

**PSED 1, objective 2, sub section (3(a)(b)(c))**
PSED objective 2, sub section (3)(a): ‘remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic’;

Travel:

The differential impact table above shows that in the case of public transport some protected characteristics will be affected more than others. As such the unit will endeavour to support patients (PTS) and cares/key loved ones with help with transport (HCTSC) were they are on the extremities of travel, both in cost and time.

Service provision:

The unit has a track record of working with diverse patients and puts the patient’s welfare and wellbeing front and centre of its concerns.

As the new unit comes together and staff may be taking on different roles and responsibilities, it would be an advantageous time to review its policies and practices around:

- Supporting key visitors with physical disabilities, sensory disabilities (e.g. Deaf or blind), mental health and learning disabilities.

- Treating and working with Trans patients: although a statistically small percentage of the population identifies as trans, the unit nonetheless has to prepare for how it will support and treat trans patients and potential ethical issues that may arise; for example – should the unit continue hormone treatments if a person is in a coma, or is incapable of expressing their wishes? If a patient has such neuro damage that they cannot identify themselves – and they have been scheduled for transformation surgery – should this continue? What if a trans patient has difficulty in making decisions and the unit is looking to the family, but the family is set against them being trans? If a trans patient fully recovers and finds out that treatment has been withheld, what is the legal standing of the unit?

These are just some of the issues. The unit needs to set up links and consultation with the trans community to look at the types of issues that could come about as part of the neuro-rehab process and establish policy and protocol/guidelines

PSED section 1, Objective 2, sub section (3)(b): ‘take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it’;
Travel: In addition to the protected characteristics linked to disability, three other protected characteristics may need particular support when it comes to travel and the reliance on public transport:

Women who are pregnant – patients’ wife’s/partner’s may be pregnant and have difficulty using public transport – care and consideration must be given by the unit in how they can support such visitors.

Cancer patients (under the equality act 2010 count has having a disability) that may have urological or other problems that may mean they struggle with the length of travel - care and consideration must be given by the unit in how they can support such visitors.

LGBT and religious dress (kippah, burqa etc): Growing rates of hate crime can be seen targeting LGBT and particular religions, especially anti-Semitism and Islamophobia. Where loved ones of patients are fearful of attack (or have been subject to attack whilst visiting loved ones) the unit will need to show support and help evaluation travel options and arrangements.

Service provision:

The unit has a track record of working with diverse patients and their families and puts the patient’s welfare and wellbeing front and centre of its concerns.

As the new unit comes together and staff may be taking on different roles and responsibilities, it would be an advantageous time to review its policies and practices around how to support pregnant women, LGB patients and visitors, and different religious needs of patients and visitors.

PSED section 1, objective 2, subsection (3)(c): ‘encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low’.

Transport:

As highlighted above, any impact on travel, such as lengthening time of travel or the interchanges needed to catch different buses/ tram combination will be magnified when it comes to disabled people using public transport. In addition, 50% of disabled people since 2017 have now lost their mobility component to their benefits5 meaning that disabled people are more isolated and more reliant on public transport.

In addition, since March 2018, over 33 bus routes, including routes to Manchester Royal, have been decommissioned. In addition, bus routes are constantly being altered or suspended, this means it could be a real challenge for loved ones of patients who are disabled to travel to visit them and play an active role in the patient’s rehabilitation whilst the patient is an inpatient. Visiting loved one’s in hospital is part of ‘public life’ something that the majority of people take for granted.

As such the unit needs to consider section 20 of the Equality Act 2010 ‘reasonable adjustments for people with disabilities’ (and their carers) and offer support, in helping with travel and travel plans. Where the unit sees that travel is extremely difficult and too burdensome (time and costs) then the unit needs to explore alternative ways it can support such a carer, especially where the carer is essential to the patient’s wellbeing and rehabilitation and/or the carer themselves have a disability that impedes travel.

The unit needs to monitor such demand and if PTS and HCTSC is not meeting their needs, then to look at considering funding some form of ‘taxi arrangement’ in exceptional circumstances.

**Elderly/Aged** – statistical data from the unit shows a higher proportion of elderly patients, this may mean wives/husbands/partners giving them support may be elderly too – they may need help in organising their public travel arrangements. The unit must consider giving assistance with this.

**Service provision:**

The unit has a track record of working with diverse patients and their families and puts the patient’s welfare and wellbeing front and centre of its concerns.

As the new unit comes together and staff may be taking on different roles and responsibilities, it would be an advantageous time to review its policies and practices around how to support visitors that have disabilities and how to support older visitor too.

**PSED section 1, objective 3: foster good relations between persons who share a relevant protected characteristic and persons who do not share it.**

This objective is typically used for community cohesion projects. As the programme at hand is focusing in restructuring neuro-rehab facilities, then this objective is not engaged nor its qualifier section 5.

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6 [https://www.manchestereveningnews.co.uk/news/greater-manchester-news/33-bus-services-cut-curtailed-14371157](https://www.manchestereveningnews.co.uk/news/greater-manchester-news/33-bus-services-cut-curtailed-14371157)

7 [https://www.manchestereveningnews.co.uk/news/greater-manchester-newsstagecoach-first-buscanceled-thursday-14347328](https://www.manchestereveningnews.co.uk/news/greater-manchester-newsstagecoach-first-buscanceled-thursday-14347328)
PSED section 2: – ‘A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1) [the 3 objectives]’.

When the neuro-rehab centre commissions services by third parties (e.g. private health contractors) who provide a service to the public (e.g. patients) then the commissioning process must ensure that PSED is part of the tender process and service specification.

PSED section 4 – ‘The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons disabilities.’

The above section (objective 2 (3) (a) (b) (c)) covers and inculcates PSED section 4

PSED section 5 – Not engaged

PSED section 6 – Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

The above section (objective 2 (3) (a) (b) (c)) covers and inculcates PSED section 6

7. Recommendations:

The committee can accept the proposed changes to the neuro-rehab service design and delivery as they meet the statutory requirements of the Equality Act 2010 and in particular section 149 – ‘Public Sector Equality Duty’ as long as the recommendations in section 5 and 6 above are reviewed and taken in to consideration.

8. Actions for the new neuro-rehab unit – linked to equality implications.

1. The unit continue to deliver high quality service and continues to place the patients and key visitors at the heart of the patient’s recovery.

2. Unit to review how it supports key visitors to the patients by offering advice with travel PTS and HCTCS and ensuring those pathways for support are known to patients.

3. The unit start to record how key visitors travel to see patients, noting in particular public transport use and any difficulties with public transport (Time/cost/delays/cancellation of key routes). After 12 months review the data, if the data shows that
some visitors are having great difficulty, especially linked to disability, then the unit to consider how more immediate support can be given (e.g. taxi service)

4. The unit to review its equality policy and how it supports different protected characteristics and their needs, especially trans patients. Link with key community groups for their input and update policy and practice where necessary.

5. Link, as part of evidence gathering, with the Mayor of Manchester’s campaign to bring all bus companies back in to one service provision.